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JAMES ATTERHOLT, Commissioner

TO: Indiana General Assembly Legislative Council

FROM: Carol Cutter, Chief Deputy for Health and Legislative Affairs
Indiana Department of Insurance

RE: Current Preauthorization Practices and Procedures Used by Insurers and Health Maintenance Organizations ("HMOs")

DATE: November 1, 2007

Pursuant to Senate Enrolled Act 372 (Pub. Law No. 56-2007), the Department of Insurance ("IDOI") submits this report regarding the current preauthorization practices and procedures used by Indiana insurers and HMOs.

I. Summary of Report

This report will provide a description of the IDOI's study of current preauthorization practices and procedures used in Indiana. We will describe how we gathered information and provide some accounting of the costs and benefits of preauthorization. We will list the possible legislative responses that were suggested during our study and make recommendations. Finally, we will briefly address standardization of other items the IDOI was permitted to study.

II. The IDOI's Assigned Task

The IDOI was charged with studying the current preauthorization practices and procedures used by insurers and HMOs. Preauthorization procedures relate primarily to non-emergency/non-urgent surgeries and radiological services, specialists, and prescription drugs. The Department was asked to allow representatives of insurers, HMOs, and health care providers ("HCPs") to provide testimony concerning whether the current preauthorization practices and procedures require the establishment of standards to ensure uniformity, timely response, and the provision of reasonably sufficient information to health care providers concerning payment of claims.

The IDOI was also permitted to study standardization of:

- explanation of benefit forms;

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- the length of time an HCP has to submit a claim for payment for health care services to an insurer or HMO;
- the format, information, and location of information concerning health benefit cards; and
- the manner and time frame in which an out of network HCP is informed by an insurer or an HMO of the reimbursement rate the HCP will receive for a CPT code of a health care service for which the HCP receives preauthorization from the insurer or HMO.

III. Information Gathering Process

The IDOI held three public hearings, which were advertised in the Indiana Register. Meetings were held July 25, 2007, in Conference Room 19 of the Indiana Government Center South; August 22, 2007, in Conference Room C of the Indiana Government Center South; and September 19, 2007, in the mini-auditorium on the second floor of the American United Life Building. Transcripts of these hearings are available upon request, but due to their size were not scanned and included with this report. Insurers, HMOs, HCPs, consumers and other interested parties provided input.

In addition, the IDOI provided the opportunity for anyone to make a comment or provide information by sending email to Chief Deputy Carol Cutter. Outside of the public hearings, the IDOI held one meeting with members of the insurance industry, and one meeting with members of the Indiana State Medical Association. Those meetings took place at the IDOI office. Also, a letter on the subject was received from Michael Yoder, CEO of Southside Family Medical Group, LLC., who attended the public meetings. That letter is also included with this report.

IV. Costs and Benefits of Preauthorization

The IDOI was unable to secure any specific studies indicating the cost versus the benefit of preauthorization. However, Linda Barrabee, Regional Vice President for Anthem Blue Cross and Blue Shield, stated that since Anthem put preauthorization procedures in place, it has saved $5.8 million on radiology services in Indiana. (9/19/07 transcript, pp 21-22) She further stated that Anthem projected its claim payments in Indiana would increase by $135 million if preauthorization was disallowed, based upon their actuaries' reviews.

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HCPs argue that much of the savings realized by the insurers is offset in the cost to HCPs for additional staff to process preauthorizations. Robert Clutter, M.D., estimated that his office, which services approximately 100 patients per day, spends generally $50 per day – or $0.50 per patient – on preauthorizations. (9/19/07 transcript, pp 32, 37-38) Much of this time, according to the providers, is spent on hold on the telephone. Mr. Yoder's letter stated that they spend approximately $25,000 per full-time equivalent physician per year to process referrals, pre-certifications, and prior authorizations. (Yoder letter, p 2)

V. Points of Contention surrounding preauthorization procedures:

a. Limits on Retroactive Denials

Although there was no conclusive evidence that this practice is frequent or widespread, it is the driving issue for providers' opposition to preauthorizations in any form. To address this, the IDOI reviewed actions other states have taken in dealing with this concern. Alaska, California, Colorado, Connecticut, Florida, Idaho, Kentucky, Louisiana, Maine, Maryland, Minnesota, Missouri, New Jersey, New Mexico, North Carolina, Ohio, Texas, Virginia, and Washington all have some restriction on denials of a preauthorized procedure. At the third public hearing the IDOI distributed the following suggested language. Representatives of HCPs and industry have reviewed and voiced general approval of it:

> When prior approval for a covered service is required of and obtained by or on behalf of a covered person, the approval shall be final and may not be rescinded by the payor once the service has been provided, except in cases of fraud, misrepresentation, nonpayment of premium, exhaustion of benefits, or ineligibility*.
>
> During an approved surgical or other invasive procedure, if a provider performs an additional (related) covered procedure due to medical necessity, coverage may not be denied solely for lack of prior approval, although the additional

procedure was not included in the original prior approval.

[*Ineligibility is a denial of benefits for not meeting the eligibility requirements of the plan.]

The IDOI would recommend this language be included in a departmental Bulletin and issued to industry and providers as a requirement of best practices to be followed.

Interestingly, it was quickly apparent from the public meetings that this concern does not exist for providers in an HMO network. The HMO provider contracts usually state that any service or procedure subsequently denied for coverage is at the expense of the provider, not the patient.

b. Requiring Preauthorizations to Be Made in Writing

Another concern for HCPs is that occasionally when they call the contact number on a patient's ID card and receive preauthorization, including the details, they may be told later (when coverage is denied) that the insurer has no preauthorization staff by that name and no record of such preauthorization. A suggestion was made that all preauthorization approvals be required to be made in writing. This is also the preference of the insurers/payors. If the HCPs will use the electronic processes on the payor websites or even fax the forms, there would automatically be a written record of the event.

The insurers indicated that although they currently provide the ability to receive written preauthorization approvals through electronic or fax processes, the HCPs do not typically take advantage of such systems. Anthem's Linda Barrabee commented that upon review of the prior approval records of a large radiology practice she learned only about 5% of the preauthorization requests were made electronically via the web, 10% were made via fax, and the rest were made telephonically. Requests made via the web or fax are not only written evidence of prior approval, they are delivered in seconds or minutes rather than hours. (9/19/07 transcript, pp 58-59) These are solutions to two of the concerns the HCPs stated

previously. It would appear that the opportunity for the HCPs to reduce costs and improve efficiency for preauthorization procedures are available in the marketplace now.

c. Waivers of Preauthorization Requirements for Certain Providers

An idea that was applauded by some HCPs at the public hearings was to require preauthorization only for HCPs new to a network and for HCPs who have been proven to over-utilize expensive services. HCPs stated that they are rarely denied preauthorization for a requested service, so they questioned its value. However, insurers responded that much of the savings from requiring preauthorization is realized from the "sentinel effect." Insurers believe that HCPs are cautious about what tests they order because they know that an unnecessary procedure will not be covered. In light of the constant changes in technology, it would likely be administratively burdensome to specify for each provider in a network which procedures that individual practitioner had to preauthorize or not preauthorize.

d. Waiver of Non-Coverage by Patient

A question was posed that did not seem to have an answer: if a patient wants to assume the financial burden of having a denied procedure done, may the HCP provide the procedure? One answer to the problem would be to indicate to the patient s/he has such a right. It should also be made clear to the patient that insurance coverage must not be the sole determination as to the appropriateness or need for certain services.

e. Requirement that Preauthorization be Available Continuously or Waived

One frustration for HCPs is attempting to secure a preauthorization outside of regular business hours. A possible solution could be to require an insurer to have preauthorization staff available continuously or, if preauthorization staff is not available, then the preauthorization requirement in the policy would automatically be waived. This situation will most often only apply to an "urgent"

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health condition, since "stat" and "emergent" services don't require prior approval. Urgent condition preauthorizations usually take one to two days, and the providers would prefer a 24 hour turnaround. This could be addressed in a departmental Bulletin, or included in a statutory change as necessary.

f. Time Limits on Responses

Another common concern for HCPs was the amount of time their staff spends either on hold on the telephone or waiting for a response to a preauthorization request. HCPs recommended that insurers be held to a time limit for responding to preauthorization requests.

Insurers insisted that no preauthorization is required for procedures deemed by the HCP to be "stat" (the most urgent) or "emergent" (needed within a few hours). But HCPs respond that, in practice, they are so concerned about a possible disagreement over whether a procedure was stat or emergent, that they will seek prior approval anyway.

The use of electronic processes will alleviate most of these concerns. There is also a new internet 'portal' that creates a 'one-stop-shopping' opportunity for providers with multiple insurers/payors. This will allow HCPs to access plan information for patients covered through Humana, Aetna, CIGNA, United Health Care, and others through just one website. Again, these types of electronic procedures should bring down the time and cost investment for providers.

VI. Other Issues

a. Explanation of Benefit ("EOB") Forms

At the second public hearing, two HCPs recommended mandating a standard format for EOBs. No other comments were received for or against standardizing EOBs.

b. The Length of Time a Provider Has to Submit a Claim for Payment

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Mr. Yoder from Southside Family Medical pointed out that often patients do not provide their HCPs with proper insurance information until months after the procedure is performed. HCPs, he argues, have every incentive to file claims as quickly as they can, because they want to get paid. He pointed out that IC 27-8-5.7-10, effective July 1, 2006, allows insurers to correct payment errors up to two years after a claim was made. Mr. Yoder proposed a similar amount of time for providers to correct their errors. (8/22/07 transcript, pp 92-94)

c. Benefit ID Cards

This topic was discussed at all three meetings. HCPs strongly desire some sort of uniformity to ID cards. The feedback from the insurers was agreeable to some sort of uniformity. The Department would like to create a version of a uniform ID card for providers and the industry to review and approve. IC 27-8-5.8 would allow the IDOI the authority to carry out this action.

One point of nearly universal agreement involved a small addition to ID cards. It was suggested that each ID card include a symbol designating whether the plan is fully insured or a self-funded plan. Insurers felt this designation would help insureds understand if the insurer or the insured's employer is the decision-maker on the plan. HCPs indicated the designation would help them provide guidance to their patients. The insurance industry indicated they would be able to make this addition to ID cards without great cost or effort.

d. Notification to Non-Network Providers of Reimbursement Rates

No comment was received on this topic.

VII. Summary

All of the participants at the public meetings were very pleased to have the opportunity to express their concerns, frustrations, and recommendations around these various issues. All agreed that just having a voice and hearing other perspectives was most helpful. In sorting through the hours of transcripts, notes, and comments, the IDOI has attempted to select those topics that received the most attention and seemed to generate the most

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concern. In each of those instances we have made a recommendation to help resolve it. For the other issues, we have left them for a future study committee who could focus exclusively on them. The only other comment the Department would like to bring to the Council's attention is a growing concern among the providers for preauthorization call centers located outside the U.S. Speaking with other nationalities who are not fluent in English about complicated medical conditions is, they state, not only difficult but potentially dangerous. Perhaps as the providers move to the electronic or fax methods for prior approval of services, this issue will diminish in importance or disappear entirely.

The Department would like to thank Senators Simpson, Lawson and Miller as well as Representatives C. Brown and Welch for sponsoring S.B. 372 to allow those providers and payors who cope with these issues daily the opportunity to examine them and help resolve several of them.

Carol Cutler

INTERIM STUDY COMMITTEE

FOR S.E.A 372

Location: INDIANA GOVERNMENT CENTER
SOUTH BUILDING
CONFERENCE ROOM 19

Date: July 25, 2007

Called by: INDIANA DEPARTMENT OF INSURANCE

Coordinator: CAROL CUTTER, CHIEF DEPUTY
OF HEALTH AND LEGISLATIVE
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Phillip Wright, MD, PHP
Becky Richey, Sagamore
Rebecca Kasper, Short Strategy Group

ATTENDEES (cont.)

Dan Seitz, Aetna, IAHP (Bose Public Affairs)
Michael Yoder, Southside Family Medical Group
Julie Halbig, Hall Render, IN Hospital & Health Assoc.
Tyler Campbell, House Staff
Claudia Stein, Advantage Health Solutions
Jeff Burniston, Advantage Health Solutions
Linda Barraber, Anthem BCBS

AGENDA

1:00 p.m.	Introduction and Explanation of Topic: Preauthorization/Precertification and Practices
1:15 p.m.	Explanation of Current Procedures/Practices
2:00 p.m.	Impact of Current Procedures/Practices: Constituent concerns/complaints to Legislators, Provider Attendees, Consumers
2:30 p.m.	Wrap-up and Explanation of Next Steps
2:40 p.m.	Meeting Adjourned

P R O C E E D I N G S

CHIEF DEPUTY CUTTER: My name is Carol Cutter. I'm with the Department of Insurance. And, as you probably know from the e-mail information that went out, part of the -- one of the tasks that the department was given during the last legislative session was to address some of the issues that the legislators here either received complaints about from their constituents. And one of them that really bubbled up at the top was preauthorization and precertification procedures and practices that exist in our world.

And as a result of that, there was a piece of the legislation that was drafted that would have probably imposed some of the certain types of restrictions on insurers and HMOs in terms of using something like this. And so we thought it better to at least have a discussion with the folks who are involved in the process or are impacted by the process. And the legislators very kindly agreed, and that's why we're here.

So the bill itself, this is Topic No. 1, the study of preauthorization practices and procedures. And the other thing that we tacked on later were

studying the standardization of the explanation of benefits forms, the length of time that a health care provider has to submit a claim for health care services to an insurer or an HMO, the formation and location of information concerning the ID cards, and the manner and time frame in which an out-of-network health care provider is informed by an insurer or HMO of the reimbursement rate that they'll receive for a particular CPT Code of health care service that has been preauthorized.

Since the department is not usually in charge of study committees, we're going to sort of fly by the seat of our pants on this deal. And we really appreciate your attending and helping us go through some of these issues.

We do have a court reporter here with us who will transcribe all of the comments and information that we exchange today, which we will certainly be glad to distribute to you. We have a sign-up sheet that I left on my desk. So it's doing a lot of good, but...

MS. KORTY: It's going around.

CHIEF DEPUTY CUTTER: Okay. Good.

Be sure and print your name and -- so whenever you're going to make comments or whatever,

questions or anything that you ask, please identify yourself so that the court reporter can -- she'll use the sign-up sheet if you'll print your name on there that she's spelled it correctly when she does the transcription. So thank you all for taking -- keeping up with those housekeeping issues.

If you have the agenda, you'll see the first thing we're going to do is talk about preauthorization and precertification, and one of the pieces that probably is critical is for us to hear from the insurer, the HMO side of the market to find out, you know, what process do they go through, what does that mean to them, what sort of functions are attached to that so that all of us kind of have a better understanding of how that works. And fortunately several of the folks here in the room today are either from a carrier or an HMO and are going to kind of give us some of that information.

The list that you see here, I don't think Kim Marshall is able to make it today, is she? I don't know her, so I don't know.

How about Claudia Stein from Advantage Health, is she here? Well, we're two oh two.

Holly, you're next. You can either stay

there and just make sure that you speak loudly enough so that the court reporter can pick up your comments, or if you want to come up to the front we've got a -- I don't know if the microphone is hooked up or not. But if you think that would be helpful for the other folks to hear what you're saying, that would be fine too.

MS. KING: I didn't prepare anything and was looking forward to hearing the two before me.

In our organization we do have certain things that have to be preauthorized. However, we leave that up to -- we contract with provider networks, so we leave that up to the provider networks. Now, we're an HMO, so we're probably a little different than the traditional insurance carrier. But basically it's left up to the providers to work out what things need to be preauthorized and what don't.

As far as our customer service center -- I think some of the issues here are probably that our customer issue center can tell, an insured when they call in, is that they can look at their group's contract and say is that particular benefit covered. But they can't necessarily get into the clinical of, you know, what needs to happen. For

instance, that there's a litany of things on morbid obesity before you would want to have gastric bypass. Our providers' networks have said they should go through these steps first.

So again, we leave the clinical stuff up to the provider and the provider networks, but our customer service people would be able to tell them, you know, yes it's a covered benefit or no, it's not.

Now, another thing I guess that's probably an issue is that sometimes a person might not have coverage at the time that they go in for treatment, and we rely on the employers to tell us when somebody's terminated or not. So, you know, you would think that that individual member would know when they're no longer employed or no longer has coverage or it's possible that he wouldn't know or possibly he knows and he goes anyway.

But we are not always going to be on a real-time basis with having people terminated from us on our system. So it's possible that the member -- or prior member will call in and say is this covered and we look and say yes, it's a covered benefit according to the employer contract, but that person, we don't have the knowledge yet that

they've been terminated.

So those are the issues as I can see them. I think there are probably a lot more issues when you don't -- when carriers don't leave it in the hands of the providers and the clinical people as to what procedures they have to go through in making sure that they meet all those requirements. In our case, you know, we advocate strongly for the members so that if that doesn't happen it falls back on the providers to absorb the cost of that. It's something that we won't okay because they didn't go through it. The member's not responsible if the provider agrees to cover it.

MS. MALOOLEY: I have a question, please.

You said that each provider network develops their own standards or protocols for prior authorization?

MS. KING: Uh-huh.

MS. MALOOLEY: You have multiple provider networks?

MS. KING: We do.

MS. MALOOLEY: And so each network may have different --

MS. KING: That's correct.

MR. YODER: Michael Yoder, South Side Family

Medical Group.

When you say "provider network," are you referring to either St. Francis Health Network or Methodist?

MS. KING: Yes.

MR. YODER: Okay.

CHIEF DEPUTY CUTTER: I have a question, too, Holly.

By the way, excuse me. I have not introduced Jerry to you guys. I so apologize. I know she knows a lot of you in the room already. Jerry is from State Personnel and we have drafted her over to the Department of Insurance because of all her prior history with health policy. And she is going to serve with me as the director of our health policy analysis and public information.

So you will probably see her at a lot of department functions from now on as we do the study committees and some of the other issues. And we're tickled to death to have her because she is a wealth of information and knowledge that will certainly help all of us.

MS. MALOOLEY: And I'm tickled to be with them, so it works both ways. Thank you.

CHIEF DEPUTY CUTTER: So let me kind of back

up and run this through.

I'm sorry. This is Tina Korty, one of my favorite attorneys from our office.

So you're my provider.

MR. YODER: Yes.

CHIEF DEPUTY CUTTER: And I come to you because you're going to prescribe some procedure that I need to have done. Should we pick an example of one? Let's say I'm going to have a hysterectomy. Does that have to be preauthorized, precertified?

MS. KING: I don't know. Let's just say it does.

MR. YODER: It's going to depend on the provider network.

CHIEF DEPUTY CUTTER: So there is no -- the first thing we can establish is there is no consistency in terms of what the procedures are that have to be preauthorized or not preauthorized.

MS. KING: With M-plan it may be very different than with a commercial carrier.

CHIEF DEPUTY CUTTER: And we'll ask that same question in a minute.

So he has said to me, okay, you know, you're falling apart, you're going to have to have a

hysterectomy. So he contacts you and asks you --

MS. KING: Well, he will probably contact his network. So the people there.

CHIEF DEPUTY CUTTER: Whoever they are.

MS. KING: And they would say if he doesn't already know, you know you need to have this and this documented for M-plan to pay it. And so he'll say, okay, we're going to have to do this and this or I'll have to send you here to do this. But everything will be coordinated. And he's your PCP, so everything will be coordinated through him.

CHIEF DEPUTY CUTTER: Okay. So I go through that process and he's done all the right things and he's filled out all the blanks and spaces and done what he's supposed to. I go ahead and have the procedure done.

Is there any way we can think of a reason why you would then come back and say, oh, well, we're sorry, it's not --

MS. KING: Well, let's say you really -- you had lost your coverage. You were with ABC company and you had terminated or your spouse had terminated, so your coverage had terminated on the 30th of the month after you went to him on the 5th, and the employer has not reported to M-plan that

you're terminated.

MS. KORTY: Is there other than a termination of coverage?

CHIEF DEPUTY CUTTER: Can we think of any other --

MS. MALOOLEY: Do you have different rules, if you will, for medical necessity determinations? Is it medically necessary, you know, if it's okay to get --

CHIEF DEPUTY CUTTER: As part of the preauthorization? Because he's got to substantiate that --

MS. KING: If it's medically necessary.

CHIEF DEPUTY CUTTER: -- in the work that he does in terms of giving that information to the network.

MS. KING: Right.

CHIEF DEPUTY CUTTER: So in his mind that determination has already been made by virtue of the exam or diagnosis that he's made.

MS. KING: Okay. The other thing -- this really isn't a good example of a hysterectomy. But let's say it was some sort of procedure that's not covered. Let's say -- because I think morbid obesity is at the employer's option whether that's

covered or not.

CHIEF DEPUTY CUTTER: What about tubal ligation? Let's say he's going to do -- why would he do that? That's a bad example.

MS. MALOOLEY: Face-lift.

MS. KING: Well, I think he would know that a face-lift or something is going to be cosmetic.

CHIEF DEPUTY CUTTER: Somebody help us out. Yes, Doug?

MR. STRATTON: Carol, my name is Doug Stratton. I'm with the with the ICHIA program, a high-risk program.

One of the other instances, and I think the point of medical necessity is a good point, if a provider calls in and says Doug Stratton needs to have this procedure and the person that takes the call at the service center says you're with ABC company, I can see that is a covered benefit. However, at the time that that call is made the provider says here's Doug Stratton's circumstances. And once the procedure is done there may be a question about that.

The medical reviewers will ask to see the medical records and the clinical information and they'll look at it and say, you know what, he

didn't need that. According to our protocol, he wasn't a candidate, he should have gotten something done in advance of that. But it will be based on a retrospective review clinically of the information saying Doug Stratton for whatever reason isn't an appropriate candidate for that.

CHIEF DEPUTY CUTTER: That's a good example.

MR. STRATTON: Now, I'll give you this one other illustration that's somewhat similar.

Certainly in the area of experimental and investigational, which tends to be very problematic, there may be a procedure that is approved for a certain situation but it's not approved for a different situation. And if someone calls and says I would like to get an autologous bone marrow transplant, here's the situation. It may be a covered benefit under this set of circumstances, it may not be under another one. And you probably will not be able to determine that until someone raises the question, you look at the clinical and medical records, and then it becomes apparent.

MS. KORTY: And so how deep do your customer service people dig when that call comes in?

MR. STRATTON: Not very. They know they

have a series of questions they'll ask. A provider office is calling and they probably have someone who knows more about it than the customer service rep. However, the communication process is not always clean, clear, exact, complete, and as a result of that there very well could be something that somebody says we'll precertify it and when you get it and look at it later say no, we won't be able to cover that.

CHIEF DEPUTY CUTTER: Dr. Wright, would you like to kind of give us an idea of what your procedure is at PHP, please?

DR. WRIGHT: Dr. Phil Wright, Physician's Health Plan of Northern Indiana, Fort Wayne.

We are an open-access HMO. We probably have a simpler situation that we're in than what's been described so far. We publicize to our physicians what procedures require prior authorization and we have forms available for them. We prior authorize inpatient stays, behavioral services, high-dollar items, some DME and off-plan referrals.

MS. KORTY: Doctor, can you speak up just a little bit? Thank you.

DR. WRIGHT: We have a fairly limited scope. We require prior authorizations for inpatient

stays, behavioral health services, high-dollar items, high-dollar DMEs, and off-plan referrals. We communicate the status of the authorization verbally and with written notification to the requesting entity, usually a provider.

We do global authorizations for inpatients so we don't break out individual parts of the authorization to individual providers and do an entire -- all the services related to all the admission at once, generally anyway. Our prior authorizations are dealt with by nurses and clinical personnel and in our case management office.

That's mostly how we're set up. This allows us to do case management. It drives certain benefits and prevents payment for non-covered items.

CHIEF DEPUTY CUTTER: Do you, Dr. Wright, or do you, Holly, do you have any sense of how many of those types of situations pop up where there's been a preauthorization or a precertification --

MS. KING: That Doug described?

CHIEF DEPUTY CUTTER: Well, where it's ultimately denied for whatever reason. Do you have a sense of that?

MS. KING: It rarely happens because in our case the clinical review is not done afterwards. I mean, that doctor wouldn't be performing that service until his network approved it. So it's really unique, I think, to the commercial world or we're unique in that it doesn't -- we offer it anyway.

CHIEF DEPUTY CUTTER: Just because of the procedures you follow?

MS. KING: Right. And I think that's reflected probably in our complaint indexes and stuff, that we just don't have that many denials.

DR. WRIGHT: Ours is similarly done.

CHIEF DEPUTY CUTTER: Are they?

DR. WRIGHT: They're mostly done beforehand and occasionally have somebody who ventures out and we have to retroactively deny something. But we try not to have that be the experience, and it's a fairly small number that we've had experience that.

MS. KORTY: Is that a number that you track?

DR. WRIGHT: We haven't, but it would be very easy for us to.

CHIEF DEPUTY CUTTER: Are there any insurer representatives in the room that can speak about procedures and practices? Shawn, can you do this

from the network perspective or not, or would you rather not?

MR. GIBBONS: I'm Shawn Gibbons and I'm with the State Association of Health Plans and also Indiana Health Network.

I guess a little point of clarification, because when we talk about network, we talk about an HMO or insurer who may have their own contracts with providers as part of their network can be different than another carrier used as an organization like an Indiana Health Network or a Sagamore as a rental unit. And in those instances, you know, it can be a little point of clarification as we're discussing where the network is not responsible for any of those preauthorization practices.

CHIEF DEPUTY CUTTER: So they go directly to the carrier?

MR. GIBBONS: That's strictly going to the insurance carrier --

CHIEF DEPUTY CUTTER: And the policyholder that covers that?

MR. GIBBONS: -- and those polices and procedures, exactly.

CHIEF DEPUTY CUTTER: Any other comments

related to that from anybody else?

MS. MALOOLEY: Shawn, let me ask you one point of clarification.

In the case where it's between the carrier and the patient, if you will, there are no retrospective denials then? And if so, where does the responsibility lay?

MR. GIBBONS: I actually couldn't speak to that. That would -- that's not information that I would then get from the health carrier are those retrospective denials.

CHIEF DEPUTY CUTTER: As a rental network, since you're not involved in that process, there wouldn't be any reason for them to make that information available.

MR. GIBBONS: Not only would we not hear about it, they would have no reason to notify us.

CHIEF DEPUTY CUTTER: Right.

MS. KORTY: Holly, do you know the answer to that? Is it the health care provider? If they have set up a preauthorization and then it's later denied, the health care provider is the one who then eats that cost or the patient?

MS. KING: In our model -- again, it's a very different definition.

MS. MALOOLEY: Because yours is done prospectively?

MS. KING: Right. And our contracts are with the provider networks; whereas, I think you're talking about like a Sagamore or somebody that has like an IHN who has a network of providers.

MS. MALOOLEY: So then it would either be the patients or the carrier?

CHIEF DEPUTY CUTTER: Right. Yes.

Well, we're sort of in a quandary, aren't we? Because it sounds like --

MS. HART: I actually have another scenario.

CHIEF DEPUTY CUTTER: Okay.

MS. HART: I'm Marcie Hart and I am from Arnett Health Plans, maybe United Health Care, I don't know what to call us anymore.

We have a different situation in that our prior authorization process starts with the physician. We look at whether the member is at risk for going outside of the network or being at risk for getting a service that they really shouldn't get in the first place. We want to try to capture that up front.

With that said, obviously there are certain services that a physician is more capable of

recommending that we can subscribe to him. So we have a lot of physician input. In the scenario that you were talking about, whether it's the member risk, the carrier risk, or the provider risk, our situation is the member ultimately is at risk because they are the one purchasing the health plan.

However, with that caveat, we have contractual arrangements with our providers that if they don't follow the rules, then they have to be at risk. If it's a non-contracted provider, then that does put the member in between and it will be worked out among the carrier, the provider, and the member at that point. But as contracted providers they are at risk for following the preauthorization process.

CHIEF DEPUTY CUTTER: Just for the general audience, how does either a covered person or enrollee or subscriber or member know what procedure has to be precertified? Is that information communicated to that person or not? Or is that like in the HMO world, is that something that you as the provider are required to do?

MR. YODER: Can I answer that?

CHIEF DEPUTY CUTTER: Please.

MR. YODER: From our perspective, we have so many different carriers that we deal with, it's hard for us to know from one to another what is required for precertification and what is not. And it's very difficult for us to stay on top of that. So a lot of times we simply rely on if we're ordering tests the provider of the test to come back and say you need this preauthorized, you need to be precertified before we will schedule it.

There are certain plans that we know by default, such as St. Francis Health Network, if we're going out of network we have to get that preauthorized. We know that. But there's a lot of things in between that we just simply do not know because there are so many different plans that we have to try to manage, that it's virtually impossible.

CHIEF DEPUTY CUTTER: I would think so.

MR. YODER: I guess the one question that I would have, and if this is not the appropriate time --

CHIEF DEPUTY CUTTER: Go right ahead.

MR. YODER: -- if a prior preauth or prior precert is denied as not medically necessary, can the patient -- and this is something that I haven't

got a clear answer on yet -- can the patient sign a waiver saying, you know, I understand they're going to deny it, they're not going to pay for it, they're going to come back in the EOB, Explanation of Benefits, tell the payer or the provider not a covered service or not authorized, can the patient assume responsibility for that even as a contracted provider?

MS. HART: Speaking from Arnett plans, yes. However, what you do set yourself up for is that a physician recommending a service isn't necessarily in the health plan, then you're at risk for the appeal process and its interpretation. So it's a fine line. It really depends on I would think good communication and a good understanding of the member or the patient's actual coverage and clearly communicating that it is not covered and everyone has the same understanding. And that maybe needs to be said five different ways.

MR. YODER: That's true.

CHIEF DEPUTY CUTTER: Well, and I think on the insurer's side there's certainly that opportunity because all of the contracts that carriers issue are actually reimbursement contracts. It says you as the person covered,

you're supposed to go out and expend the money, you know, create the expense, and then submit that to the insurance company, and then they're supposed to turn around and reimburse you for whatever portion of that cost is your responsibility. But with the assignment of benefits process that probably is a hundred percent of your patients probably use, then you have an opportunity to collect that money directly from the company. But if it's not a covered service, then that leaves that person on the hook for whatever expenses they have incurred. Or if they've used an out-of-network provider, then they don't have much -- not too many places to hide either.

Do you have another question?

MS. KORTY: Well, I was wondering do you have processes or procedures if a preauthorization is denied, that either the provider can come back or the patient can come back and try to change it out?

DR. WRITE: Yes.

CHIEF DEPUTY CUTTER: One of the questions that we're sort of curious about is: Does the preauthorization/precertification practice or procedure, does it really end up to be cost-saving

for you guys? Does it change things that much? I'm not doubting that it does. I'm just asking the question.

MS. DORAN: Gail Doran from PHP.

For us, yes, I think initially, especially with the advent of HMOs, there was a culture of precertify or preauthorize every single service and you had to take a step back after a couple of years of doing that and say what really do we gain from precertifying. And when Phil answered that we are fairly simplistic, that's something we review every year, what gets authorized, how many get approved, what gets denied, and the denials should always be up front. And that's where you have to get your cost savings.

Some are set in the effect of preauthorizations. You know you have a provider out there or you know that you have the latest and greatest in some medical equipment that was recently bought that suddenly everybody in the world's going to start having this scan or that scan that you put a preauth in for.

But for the most part, I would say as the health plan, yes, they do save money. But I also would advocate that they are somewhat inproficient

for the patient. Phil may disagree.

MS. MALOOLEY: Sorry, Doug.

MR. STRATTON: I would add to that, and I agree with all those comments, I think it had the greatest impact early on in terms of changing some behavior, and I think everybody is starting to adjust to that.

One of the real advantages that I see in it is that it is the earliest opportunity to see when there's a potential significant case coming down the track. And for those that are actively involved in medical management, for those that are aggressive in terms of case management and working with disease conditions, it's probably the earliest opportunity to say, you know what, we probably need to track Doug Stratton. That's the second time that somebody has said we need to take a chest x-ray of him, he's now 59 years old, ya-dah, ya-dah. And that will become a very early warning mechanism and a very effective tool.

And I would argue in some instances I would want to know even if you were going to assure that you've precertified virtually all of those procedures, but it's the type of thing that you really ought to have some clinical people looking

at early on.

MR. YODER: Can you not gather that same information by reviewing claims submissions?

MR. STRATTON: Well, claims submissions are well after the fact, and you may be losing some very critical time. But that's true, and that happens as well. And that tends to be much more clinical evaluation and case studies that look at broad macro sorts of things as opposed to looking at Doug Stratton's particular treatment.

MS. KORTY: So, Doug, what happens if you take out that Doug Stratton had his second chest x-ray at 57? What happens from there? Can you describe that for us?

MR. STRATTON: Well, ideally what would happen is whoever is involved in the initial precertification or preauthorization review process will notify someone that's in either case management or disease management in our organization and will say here's a case, and it's all done electronically, they got this, they send it automatically to someone else and it shows up on their screen.

And essentially then it becomes that person's responsibility to check into whatever

medical information that you have about this particular patient and begin the process of saying we need to do something proactive. And that's when our clinical people will become involved at that point.

MR. YODER: That's when your clinical people become involved. They're asking for information from the doctor's offices, from the specialists, and bring all that together and doing what?

MR. STRATTON: Well, it depends on the circumstances, obviously. And there are some instances where this process gets voided very early because they realize that it's part of a routine physical this time, so they'll say nothing happens, don't do anything.

Now, taken into the circumstance that you're suggesting, what will happen is a physician will be contacted, given a heads-up, and they will be informed to make contact with whoever the physician is or provider is that's providing these services just to simply say we wanted to make you aware that Doug Stratton has this information associated with this condition. And particularly in a case with drug utilization where there's a therapy associated typically with that kind of condition and you know

that there's other drugs that this person's on that's contraindicated and would be inconsistent.

And if everything worked right and the systems were perfect and you had the smartest people taking a look at it, you would be able to detect pretty early on some things that you clearly want to avoid or some things that clearly would be of benefit in the circumstances.

CHIEF DEPUTY CUTTER: And just as a matter of a side, the entity that Doug is the executive director for is the State High Risk Pool. And that's all they deal with are people with extreme health conditions, and they have probably one of the most successful disease management systems in place. There are a lot of other risk pools and other entities that are always picking his brain to find out how they do what they do as well as they do. We're just tickled to death to have somebody in that process for us, because it sure helps all of us as taxpayers that we all are.

Any other comments along that line or any other descriptions of procedure or circumstances that would be helpful for us to know at this point?

MR. STRATTON: Sorry to dominate, Carol. But I have a question for you.

What was the impetus for this study? Is it complaints that are coming to legislators? And if so, are those coming from providers that say we're wasting way too much time here to go through justification with the carriers? Or is it coming from the consumers that are saying I'm getting stuck in the middle and I got stuck with a bill for $11,000? My doctor said it was precertified. I assumed it was good and now I find out I'm stuck with the bill. What's driving this?

CHIEF DEPUTY CUTTER: I would say both of those things. I think the legislators that raised this issue see both sides of that and they've heard from both sides of that issue, both from constituents who had -- I mean, all of you in this room I think have been in this industry long enough to know that the average consumer of health care services hasn't got a clue about insurance or HMOs and how they function and what all these words mean.

And when you tell them they've got to preauthorize or precertify some procedure, you know what that means to them? You're going to pay for it, it's covered. If you're going to make them jump through those hoops -- why would you make them

jump through the hoops if it's not going to be paid for anyway? I mean, just for the rational, elementary mind, that's the conclusion that they come to.

And so I think there's been enough anecdotal history on this particular topic that I think that's probably what ultimately generated the impetus. And it was -- I'm grateful that the legislator who was concerned about this gave us this opportunity. Because otherwise, you guys would be sitting there going you mean we have to do what. Trust me, it was going to be pretty ugly. So this is a good thing. This is actually a good thing.

But, yes, that's probably helpful to know what drove that. This didn't come from the department at all. That's not our role. We're just sort of the coordinator of the information as it were.

MR. BLINE: Ralph Bline of the United Health Care and Arnett Health Plans.

We were, just by way of background, Arnett HMO was acquired by United at the end of last year. And so I have with me, and she's already spoken, Marcie Hart who is currently the manager of

operations for Arnett, and continuing Arnett, and was also for many, many years manager of the member services department. So she's been in the front lines of all of this preauthorization interfacing with the members.

Just to sort of reiterate at the risk of being redundant what PHP said, because we're structured somewhat similar to them, but historically over the years we have found due to pressures from various employer groups and members that -- and efficiencies, too, I guess, in getting things done, we are requiring fewer and fewer procedures to be precertified or preauthorized.

However, there are still several current ones, like PHP mentioned, like where, for instance, MRIs, where you can see television advertising open MRIs. And the consumers out there seeing those ads, and so everybody wants an MRI for any purpose at all and feels they haven't gotten good value from their health carrier if they can't get an MRI. And if there's no real reason, an MRI wouldn't solve any situation. And so for those it's absolutely necessary I think to keep precertification in place for certain things.

Marcie, can you elaborate on that?

MS. HART: I think the term *latest and greatest* was probably the best. I think we're all taxed with changing the health care environment and lowering the cost so that that does equate to lower premiums that are passed to the consumer. And that preauthorization process is set up twofold.

One, let's be clear, you know, so the health plan makes more money on their premiums because they're saving dollars, and also to give the best value to those members while still providing the appropriate care. No one is saying that an MRI is inappropriate in many instances. But oftentimes, using the MRI example, an x-ray is just as sufficient. And the general consumer is only hearing these catch phrases, I want an MRI, when actually you might need an x-ray.

CHIEF DEPUTY CUTTER: So is it the considered opinion of everybody in this room that if precertification or preauthorization went away, that that would have, I'm going to use the word dramatic, impact on the cost?

(Majority of attendees response of yes.)

DR. PATTERSON: I'm David Patterson. I'm a physician in private practice.

I hear your comments and I hear where you're

coming from from the provider's side. But from the physician's side, I think you're missing a big part of the equation. And that is the cost of me hiring staff just to take care for preauthorizations and precertifications is astronomical. I'm getting squeezed from every end. I've got the government telling me, I've got insurance companies paying me less and less every year, and I've got more and more rules to follow including preauthorization and precertification.

I have to hire people to do this. I've got a business degree and I still can't do this very well. I have a BA in addition to an MD in addition to a master's degree. I mean, this trouble I think that we have as physicians are incredible, and I don't think that the providers are really aware of what's going on. You know, we have to write all of these appeal letters about why we want something done. The cost to me to do that, I've got to go research it, I've got to have someone type it up, I've got to submit it. For something that I'm already trained to do, it doesn't make sense to me.

In my experience most of these things that we ask for preauthorization and precertifications on are never denied. So why is the process in

place if we're not getting denials? I can't tell you the last time I was denied a procedure for something. Other things are trivial. They make no sense at all.

For example, I'm on my way to this meeting today and I get a call on my cell phone for someone wanting a preauthorization for generic Allegra. It's the cheapest allergy medicine on the market, folks. The only thing cheaper is Claritin at Sam's or Costco. And I have to take my time out and have my staff's time to get a preauthorization for generic Allegra. Now, I've written the generic. I've tried to save you all money. And in turn you put bureaucracy back on me to get a preauthorization for this. It makes no sense at all.

That's why physicians are upset about that. And I think if it continues, they're going to get a lot of pushback. So patients are upset about that, too. And we're talking about drug interactions and saving all this for drug interaction when I get this information from insurance companies about all this important drug interaction and we acted on it in good faith, it turns out never to be true. The information they send me is not correct. Either

I'm not the provider, they're not on that drug, the information is wrong. It's rarely useful.

When I talk to my colleagues and say what do you do with that, we uniformly throw it in the trash. Throw it in the trash. Why would you do that? We're trying to help them. Why would you throw that in the trash? Because it's never accurate. It's never true. It's not helpful at all. It's a big nuisance.

For example, let me give you a specific example. An insurance company will send me a letter saying Mrs. Smith has asthma according to our records and yours. We don't see where she's had a rescue inhaler. And because she has asthma she should have a rescue inhaler. That's important. We need to make sure. Well, it turns out Mrs. Smith is given a sample in the office. We had to go take the time, process the letter, look at the medical record, call the patient, respond to the letter. Do you know how much time and money that takes? That's an enormous amount of resources in the system.

MS. MALOOLEY: I have a question.

DR. PATTERSON: It's very arduous.

MS. MALOOLEY: I understand where you're

coming from and I've heard this a lot.

So my question is: Carriers, do you maintain a list of prior authorization requests that actually save money instead of cost money to the providers, those that really do make a difference? Generic Allegra, to me as a layperson, just seems a bit odd.

MS. HART: Arnett Health Plan actually annually reviews to see the ratio of authorization requests that come in versus what is denied and see what really makes sense because, one, we don't want to do that and, two, you are the best knowledge out there to know what's right for your patient.

So going back to an easy example with the MRIs, you know, we only have very specific MRIs that need to be approved. Not all of them are authorized because we just don't deny them, just as an easy example.

So I think if a health plan is continually evaluating what really needs to be authorized and look at the reasons why, making sure that, one, they're going to get the best health care for the cost and, two, the ease of the process. We don't want to make things so excessively cumbersome that no one's going to --

MS. MALOOLEY: But the question is: Do you have a list and do you know how many have been denied --

MS. HART: Yes.

MS. MALOOLEY: -- and the percentage? For example, I believe several years ago Medicaid dropped -- this is years ago -- everything had to be -- we needed to do a prior authorization, okay, which made us really not want to see Medicaid patients in this practice because, you know, they failed one test and we have to have it prior authorized and it takes a week or two to get that done. And finally they just realized that they approved approximately 98 percent of the things that we needed to get prior authorization for. They dropped it.

MR. YODER: I guess my follow-up question to that or in addition to that is: Do you track it by test? For example --

MS. MALOOLEY: Right.

MR. YODER: I wish Anthem were here because --

MS. MALOOLEY: A procedure code.

MR. YODER: -- I have a question regarding CTs. We are a family practice office, and I

respect a lot of what you're saying. But it sounds like you're trying to pull back. Whatever happened to the primary care being the gatekeeper? Years ago the discussion was let the primary care be the gatekeeper so they can watch all these tests, so they can make sure we're not overprescribing these tests.

CT scans and Dopplers we have to get precertified. Those are an emergent requirement typically. Those are not something that can wait. But we have to spend up to 30 minutes, and I've seen my staff spend up to an hour on the phone trying to get these precertified and prior authed. That's an extreme, the hour is the extreme. But 20 to 30 minutes is not uncommon, because they're talking to a layperson on the other end, a technician who's not a nurse necessarily. Not every health plan has nurses or MAs answering those questions.

So that's taking my nursing staff away from their duties of bringing the patients back and getting them seen by the doctor. A CT scan, we're looking for specific things. The patient comes in with a sudden onset headache, they come in with a worsening headache condition, they're coming in

with a change of mental status. So we're looking for some very specific things when we order a CT scan. We always have the option of sending that patient to the ER, in which case they will get a CT scan without question.

MS. MALOOLEY: But at what price?

MR. YODER: But at what price. And that is the point, at what price. Our patients prefer to come to us as opposed to waiting two or three hours. The ERs are already overloaded.

MS. BARRABER: I'm Linda Barraber with Anthem.

With emergent procedures, you are not required to get a prior. You need to see that patient and have a CT scan done, you do it and you call afterwards. That's been the process that's been in place at the beginning. If you're having difficulty with that --

MR. YODER: My question is: Why do we need to preauthorize for something as common as a CT? It's just adding paperwork. We've never had a CT scan denied.

MS. BARRABER: And I'll be honest with you, if you look at the numbers of precerts there haven't been any. But the sentinel effect has been

so dramatic that the cost of services for MRIs, CT scans have dropped in double digits because of that.

When you have situations where you have scanners that were in dental offices that are now being used by podiatrists, it's been being overutilized. So that's why we put that in place, because people were not doing an x-ray but going directly to the other scans. But if it's an emergent situation, we do not require, we do not require a precert. You call after the fact because we don't want the claim to be denied.

MS. MALOOLEY: But what about just a telephone call saying this is the ICD-9, tell me if this is going to be paid for right there on the phone?

MS. BARRABER: Yes.

MS. MALOOLEY: Here's the ICD-9 we're going to use.

MS. BARRABER: Yes. We have a precert line to go through or you can do it on the web.

MS. MALOOLEY: Without a retrospective lookback you okay it based on the ICD-9.

MR. YODER: The problem is that the provider of the CT scan will not submit to scheduling until

we get a precert in hand.

MS. BARRABER: If it's emergent, they shouldn't. And if we need to work on that --

MR. YODER: Because we have difficulty of getting paid in arrears is what they're telling us. So therefore, their policy has become without that precert number --

MS. MALOOLEY: They won't do it.

MR. YODER: -- we will not schedule it.

MS. BARRABER: If it's a routine -- and I say routine -- if it's not emergent, absolutely acceptable. These can be done on the web and they can be done very quickly. So if I need someone to come out to your office, I would be happy to do that.

MR. YODER: Great. We'll talk later.

MS. MALOOLEY: Dr. Wright?

DR. WRIGHT: We have -- and I hope most payers do this -- but we have regularly looked at our prior authorizations, because they are working for us, too. It's impossible to measure the effect of prior authorization because of the sentinal effect that she made reference to. That is -- it's hard to measure what doesn't happen.

Once people know that there is a certain

procedure, for instance, that is not going to get covered, you don't need to send a request for it, and the network knows that. We don't preauthorize CTs or MRIs at all. I probably shouldn't have the said that at all. I will probably have a million of them. And we could at some point do that. But we really have worked hard at eliminating unnecessary ones, but there are some out there that have an effect.

I suppose you could measure it to some extent by looking at over long periods of time total numbers of procedures that come in. But when you have a procedure that can be -- that can be ordered at a time when it's not necessary or a duplication of services because somebody gets to another doctor in another center or -- I mean, the whole system is complicated enough to where it's hard to get your arms around it and get everything organized the right way.

There are certainly times when -- I mean, we've all read the stats, and having practiced medicine for 20 years, I kind of cringe at this. But I read this that when a physician practiced in a group and owns a CT scanner, those doctor order a lot more CT scans. We aren't releasing that. I

wouldn't blame someone for doing that, and we may someday. But there are a lot of things that happen that are hard to measure, and we definitely don't want to do any more -- it's in our best interest not to do prior authorizations when they aren't necessary. It's a lot of work for us. It's a headache. We don't want to bother with it.

Something that's on the web that's automatic might be a little easier, but not everybody wants to do that and not everybody even is aware of that with all of the different payers to deal with, not everybody knows with how each one works. So it gets complicated.

MS. BARRABER: And I can say from Anthem, we've done the same thing. We used to have probably books of things that we've precertified. And we've gone through and eliminated and it is not -- it's mostly inpatient services. Radiology, high imaging is one we eliminated years ago and that's when the costs skyrocketed and equipment for self-referral -- and I have radiology providers call us all the time saying when are you going to stop this, you know. Or it was a bad scan and then they get sent to a radiologist who's scanning at the hospital and they need another one and they

can't get it because we've already paid for one. And so now that person is eating the cost.

So we actually do have the data, and I don't it with me, but we looked at it and we removed it for that very reason. We did not deny that many, so what are we doing it. It's costing us money. The costs skyrocketed, it just skyrocketed. And now we're moving -- we've gone with our high tech radiology where we're actually with self-reported data from the offices credentialing the equipment so we don't have that.

And I mean, we really have been truly -- and it's self-reported by the provider looking at the magnets, the credentialing of that, we actually had a score of a hundred. We have some people that scored an eight, and I don't know that we want our patients being scanned by that equipment. An eight, and it's a self-reported data. And, you know, often that's not the right equipment either.

So those are the reasons we put that back in and then the costs then dropped drastically, so that's why we put that back in. Is it perfect? No, I'm not going to say it's perfect. We're all humans doing that. We might make a mistake with it and so the cost has dropped. And so we've avoided

those that would have just looped through the system, the multiple I've had this one and now it can't be read by the specialist and now they go to the specialist and they have to order another one. Those double procedures would have been paid in the past and now...

MS. MALOOLEY: So you are credentialing equipment which is a move towards your quality indicators?

MS. BARRABER: We just started. We just started this year, so it's new.

MS. MALOOLEY: That's nice.

DR. PATTERSON: Let me clarify something.

You're not reducing cost, you're shifting costs. You're shifting onto the providers because we have to hire the staff, take doctor time, nurse time, and staff time to do the things that you want to get your data to lower your cost. You're not lowering your costs, you're just shifting the costs on the providers.

MS. MALOOLEY: Well, you also have the employer who is paying the bill too if the employer is paying the premium. I must say that too.

MS. BARRABER: From an Anthem perspective, I would estimate that 70 to 80 percent is

self-funding. So it's the employer that insures that. When we reduce that or avoid those unnecessary tests, it goes back to the ultimate consumer. It does not come to Anthem.

CHIEF DEPUTY CUTTER: Did I see another hand over here?

MR. BLINE: I can echo somewhat with Dr. Wright. I think what you're hearing throughout the room is from the insurer's' side, it's probably I'm fair to call it a self-regulating system or it's to some degree it's self-policing. I know as the physicians, they see in their offices what staff has to be allocated to this process.

But on the health plan's side, preauthorizations are a high-pressure situation. You have to get it right. There's a time clock running, you know. You have to be adequately staffed to get that information back or you're going to have potentially seriously injured members or disgruntled at best, and that passes down to the employer, and that's -- you know, no health plan I know really wants to alienate their members or their employer groups. So to some degree it's not perfect, but it is a little bit self-regulating on just the staffing from the health plan's side too.

CHIEF DEPUTY CUTTER: I would like to ask Anthem to make sure I'm understanding this, because what I think I've heard from most of the HMO processes is that because of the way you are structured and the procedure that you go through, yours is always for the most part, you know, the provider already knows what all of the information is, they know what's medically necessary, they know this needs to be done. So there are very few opportunities for something like that to slip through that you would ultimately look back on and say oh, well, he shouldn't have done this.

MR. YODER: That's not an issue we have a problem with.

MS. MALOOLEY: That's just M-plan? Okay. That's an HMO. That's all the HMOs?

MR. YODER: As providers, I do not get a lot of patients coming to me and complaining, well, you've preauthorized this and now they're saying I have to pay for it. I don't hear a lot of complaints from patients in that regard at all.

CHIEF DEPUTY CUTTER: So with Anthem's new process that she just described, did that take it into the same realm where the physician is the one who's really already made that call and you guys

are pretty much going to say okay?

MS. BARRABER: On the web it would come back and say that. And even if they call in and say they're giving all of the documentation and it goes through, and again all of the protocols that are set up by the different societies, it's not our protocols, then yes, that's how it is and then it would be paid. They might ask for additional information for a certain procedure and then it would be paid.

On a lot of radiology and on our normal precerts, which is for an inpatient, when it has to get to a medical review, it's a nurse that's reviewing it. On the front end if it's something simple, if someone's pregnant, I always love when someone asks if we're going to deny that person or that baby. We just don't require it anymore.

MS. MALOOLEY: So Linda, are you saying that inpatient and high-tech radiology are the two major prior authorization groups?

MS. BARRABER: It used to be a lot more. And there's a few other things that are not a great deal.

MR. YODER: I have a question. You said if someone's pregnant, we're not going to deny them of

having a baby, we're going to put them in the system. So do you still require then that your PCPs call you and get some type of notification from you guys?

MS. BARRABER: (Nods.)

MR. YODER: Okay. I just wanted to clarify that.

MS. BARRABER: That's one of them that is probably medically necessary that they have the baby. It's never going to be turned down.

MS. KORTY: And just for the purposes of the record, can you say yes or no instead of the uh-huh or uh-uh?

MS. BARRABER: Yes.

MS. STONECIPHER: A question in regards to your concerns about it's very hard to manage which health plans require which items to be precertified. It's very hard to stay on top of, you can go to the website, you can get the information, but you're going to have to go there every time when these situations come up.

Is there an opportunity to somehow standardize or at least come to an agreement as to what needs to be -- I know that's a far-fetched --

CHIEF DEPUTY CUTTER: I think that's the

purpose of this exchange, honestly, is to see if there is that opportunity for us to do that.

MS. STONECIPHER: And which company requires what and why.

CHIEF DEPUTY CUTTER: Absolutely. And I think it goes to the doctor's comments. You know, the cost is there regardless of where it pops up. And so if there is any opportunity for us to eliminate that reasonably, we would certainly want to visit that.

MS. BARRABER: I do think it's important to remember that not all of the business is insured business.

CHIEF DEPUTY CUTTER: That's true.

MS. BARRABER: That when it's under ERISA, we can put that policy and procedures in place, but it's not going to cover that business, so you're still -- you're potentially setting up a separate process, so it doesn't necessarily follow those guidelines.

CHIEF DEPUTY CUTTER: That is true. That is very -- and I don't know how many of the providers that are in the room with us today that have that knowledge. But in Indiana probably somewhere 60 to 70 percent of the people who have group health

insurance are covered under self-funded plans that are not under state regulation, they're under federal regulation.

So one of the prime examples of that is the H-24 thing that's popped up. And thank you all for not bringing that up today.

MR. YODER: Now that you did...

(Laughter.)

CHIEF DEPUTY CUTTER: I've about had it up to here with H-24.

But at any rate, yeah, that's an important point, because the self-funded program can design whatever parameters they want to put together in terms of what hoops you have to jump through.

MR. YODER: Can I ask a general question to the providers?

CHIEF DEPUTY CUTTER: Sure.

MR. YODER: I don't know this answer. But do you find that your policies, your plans, this payer may require different things precertified and preauthorized as opposed to this other company? Do you find that, for example, not to pick on Anthem, but I'll use you as an example --

MS. BARRABER: We're used to it.

MR. YODER: Does Anthem have one set of one

list of all of the things needs preauthorized, all those things that need precertified, or does it depend on your payer, your company that's paying the bill?

MS. BARRABER: We're the payer. So our insured business that's governed, yes, we have one list. And I will tell you I get requests weekly from salespeople, we want to the make an exception for this. And I do my darnedest to turn it down because there's a reason we want it to be consistent.

Now, when you get to national business, and most of that is ASO, we try to steer them to the same list. But they're paying the bill.

MR. YODER: You do your best, obviously, but you can only do so much. So you do have different criteria depending on --

MS. BARRABER: By those accounts.

MR. YODER: -- those accounts.

MS. BARRABER: Yes.

MR. YODER: That's just another thing that I think -- and Anthem is not alone in this, from my understanding -- that's just another thing that makes it more difficult for us as providers, because even within the same carrier, the same

insurance company, their requirements are different depending up the plan.

MS. MALOOLEY: The employer.

CHIEF DEPUTY CUTTER: Now, to go back to her comment, what she was saying was: If it's a fully insured plan that we have the ability to regulate, it's the same across the board. But if you go to this self-funded plan or this self-funded plan, those parameters could change.

MS. BARRABER: That's right.

CHIEF DEPUTY CUTTER: And unfortunately, this department of this state has no opportunity to standardize that.

MR. YODER: It's just an idea.

CHIEF DEPUTY CUTTER: Absolutely.

MR. YODER: When we're talking about bringing things under one umbrella, maybe the department could do the website that the providers of the plans could participate in that we could go there and we could look up in one centralized location, based on this plan this is what has to be percerted. I don't know if that's too big of a bite to take.

CHIEF DEPUTY CUTTER: We have to think of everything.

MS. BARRABER: If you use, for example, and I'm certainly not saying we have this, but if we have 500 national customers, we need to have 500 different plans. And that's where it gets -- General Motors is a prime example. Their hourly people have one requirement and their salary folks have another. And you would think UAW Ford would be the same. Oh, now it could be something totally different. Which I totally agree, it's very cumbersome and very...

MR. YODER: And I understand from the business standpoint you're trying to sell policies, you want to adapt to the customers' needs. I understand that. From a provider's standpoint, it is a nightmare trying to know what needs a precert and what doesn't. And it does, it adds staff.

CHIEF DEPUTY CUTTER: No question.

MR. YODER: We are hiring staff because we have to. As a matter of fact, I just hired somebody starting this week to help with precerts and prior auths. Somebody without all of this, we would be able to save costs.

MS. KORTY: I want to make sure that you understand, it's not just that they want to meet the needs of Ford or whomever. If the State passes

the law that says --

MR. YODER: I understand. Some things are outside the State's control.

MS. BARRABER: And it's the majority of the business in Indiana, unfortunately. It's at least 70 percent of our business.

MS. KORTY: I'll get right back to you.

We've heard a lot at this point from the carriers and from the providers and we sort of promised in our agenda that we would let some others talk. Is there anyone here representing a legislator's office that wants to pipe in on this issue?

CHIEF DEPUTY CUTTER: A consumer advocacy group?

MR. CATTELL: The State Medical Association, Dr. Patterson, and Lori have been speaking from our perspective.

MS. KORTY: Where is that sign-up sheet?

DR. PATTERSON: I'm just wondering, and there have been some good comments here, because there's a large disparity in what the plans do and because we're trying to practice evidence-based medicine, why don't we let the science drive what's on the list and have a common list as opposed to

everyone picking and choosing? It doesn't make any scientific sense. It's makes business sense, but we're talking about medicine here.

So if we know which procedure from the best practice standpoint should be precertified, which ones are high risk of being abused and not, why don't we use evidence here to drive our decisions instead of people and companies picking and choosing what they want on their list and making 500 different lists?

CHIEF DEPUTY CUTTER: Why don't you give us a list? That would be very helpful, seriously. On the bottom of the agenda I have my e-mail address on there and my business cards are over here on the table. We would appreciate any input like that that you're willing to provide as we're pulling this process that we're sure that we consider all those kinds of issues.

DR. PATTERSON: I think the way that would work is the providers and the insurance companies would sit down across the table and say, okay, what's the rationale or what can we agree what should be on the list. For example, some of our bariatric surgeries, very good example. We can all bring up and we can all think of examples where

someone has the medical means to try to lose weight before we go to bariatric surgery. We'd probably agree on that, so that should be on the list. There's some good scientific evidence.

But going around doctor to doctor is not going to be good sense there. We need to have providers and insurance carriers there together talking across the table getting that list together.

MS. MALOOLEY: But isn't evidence-based medicine at this point, while we're trying to develop the quality standards, okay, very much based at this particular point on the specialty organizations developing theirs and there are some employer coalitions, National Business Groups on Health, Leapfrog, et cetera, et cetera, we are developing those criteria to be able to produce the quality and then judge the outcomes for evidence-based medicine.

So I'm not sure it's just a conversation between what the provider and the physician would determine to be --

DR. PATTERSON: Except the physicians and the providers both have those recommendations from those quality organizations.

MS. MALOOLEY: I would think that the department would want those protocols followed.

DR. PATTERSON: Sure. Right. But there's like 160 recommendations by the American Society for Quality for evidence-based guidelines on what the policy will pay for the performance. So you would think you could look at those quality recommendations that are given for pay for performance and then based on those decide, okay, which things are we going to have to precertify or not based on those guidelines of good practice instead of somebody picking off of a list.

MS. MALOOLEY: I would strongly recommend that we do the AQA, things like that.

DR. PATTERSON: Right.

CHIEF DEPUTY CUTTER: Yes, Holly?

MS. KING: I want to say in response to that, though, you know, M-Plan working with the provider network so we have, you know, like you guys talked about, St. Francis and Methodist, so these are global organizations that include all kinds of physicians and providers. And, as I said, we leave it up to each one of those individual provider networks what they want to precertify and how they want to do it and what they need a

referral for and what they don't, and they're all different.

So I think, like you said, getting consensus is not very realistic.

MS. MALOOLEY: But on the other hand, going through the Leapfrog standards, for example, with M-Plan, okay, it's more difficult for an HMO to follow those than we are a carrier that does insured and self-insured non-HMO plans. So we may have to divide the type of plan.

CHIEF DEPUTY CUTTER: Any other comments?

DR. PATTERSON: I think one of the other comments, it's interesting to me that we've been able to get together as a group between physicians and providers who agree upon a common application for physicians that is on the web --

MR. YODER: CAQH?

DR. PATTERSON: Yes -- CAQH. That's been a long time, a lot of effort, but we were able to agree on what to put in that application to potential physicians, and it's been a huge success. I think it saves providers money, it saves physicians money and time. Why can't we do the same with standards?

CHIEF DEPUTY CUTTER: We're hoping to move

in that direction.

DR. PATTERSON: It is standardization. We need to standardize.

CHIEF DEPUTY CUTTER: We're hoping that this has the opportunity to do that in some manner.

MS. MALOOLEY: Providers that are in the room, are you all signed up to participate in the Medicare quality requirements for your performance using the new G codes to be able to be paid the extra 1.5 percent?

MR. YODER: No.

MS. MALOOLEY: So you're not even participating in that?

MR. YODER: No, because of the added work. The added documentation does not cover the added reimbursement.

DR. PATTERSON: Bingo.

MR. CATTELL: In fact, the money for that Medicare trial will be not available next year. So those that are volunteering now are starting to find out that continuing volunteering are not going to get them anything.

MS. MALOOLEY: Really? Okay.

MR. YODER: We have another practice that I'm aware of who has been participating. And for

the last two weeks -- it's a struggle they've been having for the last two weeks where their claims have not been going through. It goes to a clearinghouse. When we send claims electronically, typically we send them to a clearinghouse who then forwards them on to the various insurance companies. Their claims are being rejected at the clearinghouse because their clearinghouse is not set up to receive.

MS. MALOOLEY: Well, they've also, I believe that CMS has also helped the claims at this point in time. But did you except anything more?

MR. YODER: The added benefit of revenue does not offset the added documentation costs.

MS. MALOOLEY: I would believe that.

MS. KORTY: I'm interested in turnaround times. What did the carriers -- what kind of a time frame do you require for a request for preauthorization, depending on whether it's emergent or nonemergent, that type of thing, what is your turnaround average time?

CHIEF DEPUTY CUTTER: Let's say nonemergent because that's probably more prevalent.

MS. CUTTER: And we'll have that information.

MS. DORAN: Well, just by the nature of those being preauthorization, it's prior to the service. If somebody, obviously, goes inpatient over the weekend, we just require 24 hours within the first working day. If it's a holiday, it's 24 hours after that. Most of the intakes at the hospital are set up and they just fax that information directly to us. So they do it via the web, so there's very little interaction.

From the physician's side, mainly it's they have the patient in the office and they want to, you know, nonemergent they want to have something done that requires the preauthorization, they'll contact us right then and there. And we might be a little bit unique, but our preauthorizations are done with our personal staff, our nurses. So all of the questions can be answered right then, but it's a pretty routine process.

So I don't know that we measure anything that we have turnaround times that are required from the providers. It's more a service issue than anything else. The patient is there, they don't want to see them again if they don't have to just for paperwork. So we turn it around right then and there.

CHIEF DEPUTY CUTTER: Anybody else?

MS. BARRABER: Ours is a very similar process.

CHIEF DEPUTY CUTTER: Is it?

MS. BARRABER: If they go in, the hospital calls after the fact in 24 hours, they can track it. It can be done while the patient's in the office. Or if the patient doesn't want to wait, they can elect to have it.

MS. KORTY: What about say some GYN service where it doesn't need to be done right there at the time, but it's a question of maybe medical necessity? Is that a two-week turnaround? Is that a do-it-on-the-phone thing?

MS. BARRABER: Either way. They can do it on the phone and have it done right then or they can send it in and then it's probably seven- to fourteen-day turnaround. But again, that would only be inpatient for us. Outpatient it's not required.

CHIEF DEPUTY CUTTER: Other comments?

MR. YODER: I have a general question again for the insurance companies. And again, I haven't a clue to the answer.

But as primary care docs, we have to get

precert for. And I'm going to use the CT as an example. Do ERs and hospitals have to get precerts for that? I understand if it's emergent, they'll go ahead and do it and they can get it after the fact. But is it required of ERs to get precerts for those types of procedures as well?

MS. BARRABER: The hospital does it.

MR. YODER: Okay. So the hospital will actually have to do it?

MS. BARRABER: It will go through the system without it. We're not going to deny that. But if it's questionable, they'll call in afterwards. They don't have to.

MR. YODER: So even if the hospital decides, you know what, it's not cost effective for us to go ahead and get this precert, we're just going to submit the claim anyway.

MS. BARRABER: As long as it meets the emergency definition, it will go through, yes.

MR. YODER: And how is that determined? Is it based because it comes out of the ER or based on -- how is it determined that it meets the emergency definition?

MS. BARRABER: Well, it's based on diagnosis. And then if it's questionable, then we

might ask for records. But under the prudent layperson definition, it's pretty much --

MS. MALOOLEY: It covers it.

MR. YODER: Well, I guess what I'm wondering as a PCP here -- forgive me, I'm fishing -- I'm wondering as a PCP, if we are making that emergent medical necessity call, do we then simply -- well, we don't have to submit the claim because we're not the ones being billed for it. Again, we're running into the problem that the hospital won't schedule without it.

So maybe we just need to talk afterwards and see if we can get something to the hospital and say go ahead and schedule it with these doctors.

MS. BARRABER: Well, obviously, you're going to have the medical necessity information. They're not going to have it. That is why we ask the physician that's referring them over to call us for that.

MS. KORTY: Is there anyone here from the hospital association?

MS. HALBIG: Obviously, we're not PCP doctors in the fact that we can spread out some of our administrative costs. But again, anything we can help with the standardization would be

beneficial in lowering our costs as well. You know, it's an issue that as we keep talking about this we'll take back to our members. Any specific questions that we need to take back to our members, we're happy to do that. If we need to bring someone in and give you specifics, we can do that also.

CHIEF DEPUTY CUTTER: Yes, David.

DR. PATTERSON: I was just thinking about something.

Instead of imposing a regulation for all physicians for preauthorizations and precertification, why can't the provider -- this is a question for the providers now -- why can't the providers monitor the system for sentinel events like a specialist or a primary care physician who is overutilizing something and confront that person and review their charts and do it that way as opposed to imposing regulations across the whole system?

MS. MALOOLEY: Peer review?

DR. PATTERSON: Whatever you want to call it. But, you know, if you have someone who's overutilizing a CT scanner, let's say bought a CT scanner and now they're ordering more CTs and

you're questioning that as a provider, as well you should, instead of giving preauthorization for everyone, for every provider, why can't you --

MS. MALOOLEY: Oh, for that particular overutilizer?

DR. PATTERSON: -- confront them the individual provider and say, look we respect you're a physician, but look and review those and see what's been done correctly and what's not. That would be a much less -- it seems to me would it would save both sides money. It's costing them a lot of money, it's costing us a lot of money. I understand what you're trying to track. You're trying to track overutilizing. No one would argue with that. It's the way we're doing it that's costing everyone a lot of money.

MS. MALOOLEY: Do you as carriers track high utilizers? Do you have like a little red flag so that when they order something you know who to look at? Or where you know that also you have very high-performing physicians that you really don't have to question? It's a good point.

MS. DORAN: Yes. We track -- we call them our outliers.

MS. MALOOLEY: Outliers?

MS. DORAN: Yes. You see it in narcotic prescriptions. You see it in the flat films verses the CT films. Phil can address probably more, we do have a peer review committee. I think there is some reluctance, especially in the microclimate within the state of the medical associations, if you will, every section of the state seems to have their own little climate on how the doctors interact with each other.

I think you have some success there. And I don't know what other health plans do, but that's certainly a forefront for us that if we have an outlying provider that seems to be outside of the norm in both his practice, his outcomes, what he prescribes, or what tests he runs, and certainly the claims that he submits, that he is brought before our peer review both just as a case and maybe eventually in person. And I think we have success with that.

You do have some drawbacks with that, though. Because you always have to be careful of the perception of practicing medicine.

MR. BLINE: If I understand Dr. Patterson's suggestions, I think he's advocating that in lieu of precertification, it's sort of like closing the

barn door after the horses are out. I mean, until you see a pattern that might be developing, but how that pattern's developing, a lot of costs for essentially unnecessary procedures have been run up and paid by the carrier. And I don't know what type of system should be put in place to identify that quickly enough and not at the provider level.

MS. MALOOLEY: How many years of practice would you suggest that you track a provider before you don't require authorization because of the way he practices medicine?

MR. YODER: That would be another way to address it, is have prior authorization for X number of years as a participating provider. And if you see your pattern, say, you know what, we trust this doc, he's doing a good job, we'll back off and not require the prior authorization. Still maintain the data, still watch for flags for the outliers.

MS. HART: And Arnett Health Plan actually has done that in some of the nephrologists, neurologists, some of those highly-specialized doctors. They don't have to do prior authorizations because they're not overutilizing those services. There's not anything to

overutilize in those arenas. So absolutely, I do think it works. But again, we need a good system and a standardized system is the difficulty we run into.

CHIEF DEPUTY CUTTER: Any other comments?

All good information. I think we have covered everything that the three of us have been able to think of, and you guys have certainly given us some other things to think about too.

MR. YODER: If I may, there is one prior authorization issue that we haven't discussed, and that is medications. And I don't know if now is the time to bring that up and discuss that as well.

CHIEF DEPUTY CUTTER: Absolutely.

MR. YODER: As providers one of the problems that we face are formularies. Formularies being those preferred medicines that our insurance companies prefer our patients try first, be it first year, second year, third year. Those formularies from our perspective seem to change frequently, and it's very difficult for us as providers to know which formulary this patient is on. So our doctors prescribe based on their preferences, what they see anecdotally as their best outcomes, and they will change based on the

patient's response to that medication.

Unfortunately, sometimes what happens is we get a patient established on a certain protocol and it fits fine with the formulary. The company may change insurance companies, they may change plans, they may change formularies at the insurance company, and it no longer meets the criteria.

So we get a letter sent such as this that says your patient is on Nexium. We want you to try one of these other drugs first. And we have to go through and we have to open the medical records, we have to fill out the information, fax it back in. And again, it just adds time and it adds cost when we have a patient on an existing protocol.

So this is not a situation where we're starting a patient onto a new protocol, but it's a patient who is on a protocol that is working, is functional for a patient. So again, that's just an issue that we have. I don't know how best to handle that.

CHIEF DEPUTY CUTTER: And that's becoming a larger issue just because of the types of medications that are available now and how effective a lot of them are in the different health conditions that people have. I think you guys have

much more opportunity to help control issues with patients with medications.

DR. PATTERSON: I think the best way to stall that is standardization. If as providers we had one place to go on the web, say for Anthem or M-plan or Sagamore or Arnett, instead of what PPIs you preferred, we could do that. But the patient's card doesn't really say it. The patient has no idea. So we have to guess and we frequently guess wrong, and that generates the paperwork that Mr. Yoder's talking about that costs us time and money.

MR. YODER: If I may, even then as a provider when you're seeing patients you don't have time to go on the web and say, okay, now, this is a Cigna patient, what is his protocol, what formulary do I need to follow for this patient? We don't have time for that. You have so many. You have a Cigna, you have an M-Plan, you have a United Health Care patient. You have so many different patients through so many different carriers, you don't have time to track that as a practicing provider.

Now, a lot of times what we will do as a doctor, again, the first time, and it's not a problem, we will prescribe -- the doctor will

prescribe what he or she feels is best or has had best success with. The patient then will go to the pharmacist, try to fill that, the pharmacist will call our office and say, you know what, this is not on the formulary. Can we substitute? And if it's a first-time application, yes, absolutely, it's not a problem. We're happy to try and help the insurance company and work with the insurance company.

But if we have already tried it, if we have already gone through the other medications and we really want the patient to be on Nexium, then at that point we have to fill out the paperwork, send the paperwork in, and go through the process, make the phone call, go online, go through the process to get the prior authorization. And it just, again, takes time and adds cost to the whole cost of the whole delivery of the medicine and health care.

MS. MALOOLEY: Well, with the plan design, for instance with the State, we have four levels, four tiers. And if you want something nonformulary, you just pay.

MR. YODER: But out patients -- we have customer relations as well.

MS. HART: That doesn't go over very well.

MR. YODER: That doesn't go over well with our customers, our patients.

MS. MALOOLEY: But even if you get it approved, if you get the Nexium approved, they're still going to pay for all formularies.

MS. HART: I'm going to speak to a couple of obligations that I see in employer groups and carriers having to help you out. I think as the entire employer moves to a new carrier, I think the two carriers have the obligation to share information, to not set you up to fail. If he's already on Nexium, let's get the approval in the system before the group even starts to be active, and hopefully the employer signs up at that time to get that information.

And then, two, if you have somebody who is new to a plan that changes jobs, not the entire employer group, maybe facilitating that first line of communication so you're not stuck in the office or the pharmacist is confronted with that situation where no one's happy, and all you want to do is make sure that person doesn't have heartburn.

CHIEF DEPUTY CUTTER: That's a wonderful concept, but in the real world --

MS. HART: In the real world, exactly.

CHIEF DEPUTY CUTTER: -- that's probably not going to happen, because most employers get their group plans a month or two after the other one was replaced. And, you know, the poor employees are just screaming because they don't have their ID cards yet and the employer is ready to shoot the broker because, you know... so it's a wonderful thought, but the likelihood is --

MS. HART: I agree. It's an opportunity.

CHIEF DEPUTY CUTTER: I don't assume that's ever going to happen. Yes, Doctor?

DR. PATTERSON: We're about to address the issue with electronic medical records. We are about to beta test the prescribing module update to look at a patient's formulary which is updated daily so this issue will go away. But, you know, only about 20 percent of physicians have EMR, and those who have electronic prescribing modules up to date it's much less.

So it will be standard technology eventually, but we're years away from that. Who is going to pay for the EMR and the prescribing module? That's the problem.

CHIEF DEPUTY CUTTER: But it's wonderful to

know that that opportunity is there.

I had an experience probably a year and a half ago where I ended up in a hospital in Chicago at the University Hospital, no less. I mean, these guys are supposed to be really good. I go into the hospital at three o'clock in the morning. And, you know, fortunately in my opinion I'm a very good patient. I know everything that's wrong with me. I carry my little medication card so they can just read it, you know. It's got all the dosages and all that sort of thing. So I'm pretty up on what the issues are or what we maybe should be thinking about.

So they take all of the medical history and all this, and this guy sitting in the cubicle writing all this stuff down on this piece of paper. And they run some tests and ultimately it turns out, you know, I've got low potassium because I take a couple of diuretics and I'm just ready to fall over. So they're going to do the right-in-the-arm thing with the potassium.

They later decide that even though they're going to do that, because they don't know me and I'd never been there before, I don't even live in Chicago, they don't want to let me go. So they're

going to keep me overnight just to be sure I don't die when they give me the potassium.

So they ultimately in the middle of the afternoon bring in somebody else to take the same medical information because the guy who took it in the morning is probably carrying it around with him, you know. It didn't go into any computerized process. I finally get transferred to a room about seven o'clock that night and in this room there is a counter with a laptop computer on it that nobody ever touches. I have to put a towel over it because the light is so bright it keeps me awake, just so I can try to go to sleep.

Now, I am in a bed that Hillenbrand sold to this hospital that makes this god-awful noise that sounds like a motor running about 1500 RPMs, so there's no way you're going to sleep because it comes on about every 40 minutes. Now, they think that this bed is high tech and yet they've got this laptop over here that nobody's every used.

The night nurse comes in and she says, "I have your medication."

I say, "Really? What is it?"

She looks to see -- it's so-and-so. I said, "I don't take that."

She said, "Well, I'm sure you do."

I said, "Why do you think I'm in here?"

She whips out this, I swear to God, this little piece of paper that's like this big and it's wadded up and she's scribbled all over it and she said, well, they said that you blah-blah-blah.

I said, "No, I don't have any of those things. Let me tell you what I do have."

"Oh," she says and she leaves the room with the medication and never comes back.

So, you know, the next morning it's chaos just trying to get out of there because nobody has a clue, first of all, why I'm there, and secondly, you know, what the purpose of this whole thing was. And that to me is a perfect example of why electronic medical records are critical before we're ever going to change any of this stuff, before we're ever going to keep costs down.

I mean, we can do, like you said, all the cost-shifting we want to do. But ultimately it's not going to go away unless each segment -- and all of us contribute to this. I mean, I've been in this goofy business for 40 years, and I've got to tell you, shame on the insurance companies. When my kids were born we had a $300 deductible. You

paid that before you ever -- before the insurance company ever paid a dime. Well, my daughter only cost like $200. Now, that really ages me, doesn't it? I should have made other numbers. Anyway, that didn't surprise me. I expected that.

And then the insurance company says, you know what, let's give them a co-pay and then they don't have to pay this deductible and then we'll sell more policies. Shame on us. And we have created this god-awful mentality of I'm entitled to this. I mean, I had this raging argument with our general counsel last week about whether health insurance is a privilege or a right. And it's that bad out there, it really is. We've all contributed to it, so shame on us.

There are no easy solutions, you know, there's unfortunately no easy solutions. Because if there was, he would have thought of it by now.

MS. MALOOLEY: He wouldn't be sitting here.

CHIEF DEPUTY CUTTER: We wouldn't even be having this conversation.

So we really appreciate all of the input. We're going to have two more public meetings, one in August and one in September. And hopefully you guys can -- do we have the dates for those?

MS. KORTY: The next one is August 22nd. It's here in the Government Center South, but we're in a different room. We're in Conference Center Room C.

CHIEF DEPUTY CUTTER: Full ventilation will be provided.

We'll continue with this and we will also move to some of those other issues that the department was taxed with. And during the interim, please give to us any comments, ideas, suggestions.

MS. KORTY: Data.

MS. MALOOLEY: Research data.

CHIEF DEPUTY CUTTER: Absolutely. Any of the information that you guys have in terms of denials, how many were there, how many precerts you do in a year, how many denials, what were they for, that kind of thing. Any of that will be helpful.

Yes, Elizabeth?

MS. EICHHORN: So basically will your final report just be a compilation of the discussion here or your recommendations?

CHIEF DEPUTY CUTTER: The way the bill is phrased, it asks us to make recommendations for standardization or some other process. So I think

ultimately they're going to expect some level of that from us. And that's why we want to gather as much information as we can, because we just see different pieces of it and it really will help us to understand what the whole process is.

MR. YODER: If I may again, I think this is actually a good setting for me. I've learned a little bit listening to the insurance industry as well as far as why they do things the way they do. And hopefully you've understood our perspective a little bit as well.

CHIEF DEPUTY CUTTER: Absolutely.

MR. YODER: Is there going to be an opportunity for us to get a copy of the minutes e-mailed to us or sent to us or forwarded to us? How does that work?

CHIEF DEPUTY CUTTER: We don't know yet what the distribution process will be. But that's why we had her here, because we wanted to be sure that we captured everything. We will have a court reporter at each of the meetings.

MS. KORTY: If you want a copy of the transcript, why don't you contact Carol and we'll figure out where to go from there.

CHIEF DEPUTY CUTTER: Just e-mail me at the

e-mail address that's on the agenda and tell me that you want it and we'll just blast it to everybody that wants a copy of it.

Well, you've probably been sweating long enough. We'll let you get out of here. Thank you very much for coming. We appreciate it.

(Meeting was adjourned at 2:40 p.m.)

STATE OF INDIANA)

) SS:

COUNTY OF JOHNSON)

I, Sherri L. Sego, Notary Public in and for Johnson County, Indiana, do hereby certify that the aforementioned meeting was taken on behalf of the Department of Insurance at the time and place heretofore mentioned with attendees present as noted;

That the meeting was taken down by means of stenographic notes, reduced to typewriting under my direction and is a true record of the meeting;

I do further certify that I am a disinterested person in this cause of action; that I am not a relative or attorney of any of the parties or otherwise interested in the events of this action and am not in the employ of the respective parties.

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 6th day of August, 2007.

Sherri L. Sego,
Notary Public
Residing in Johnson County

My Commission Expires:
June 1, 2008

SIGN IN SHEET

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STATE OF INDIANA)
)SS:
COUNTY OF MARION)

BEFORE THE INDIANA
COMMISSIONER OF INSURANCE

ORIGINAL

INTERIM STUDY COMMITTEE FOR S.E.A. 372
TRANSCRIPT OF PROCEEDINGS

HEARING OFFICER CAROL CUTTER
CHIEF DEPUTY OF HEALTH AND LEGISLATIVE AFFAIRS
INDIANA DEPARTMENT OF INSURANCE

CONFERENCE ROOM C
INDIANA GOVERNMENT CENTER SOUTH
INDIANAPOLIS, INDIANA

AUGUST 22, 2007

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TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

Page No.

PROCEEDINGS

HEARING OFFICER CUTTER: If you'll take your seat, we're going to get started. Thank you.

We're going to pass around these sign-up sheets, because we need everybody to sign in and put your name and your contact information because the court reporter will be taking a record of this meeting, just like we did at the last one, and that way she'll have your name to refer to and do correct spelling and that sort of thing; so be sure and do it legibly please, so we can read it and so that she can read it as well.

Did everybody get an agenda? They're up here in the corner of the room as you come in down that first aisle.

My name is Carol Cutter, I'm the Chief Deputy of Health and Legislative Affairs for the Department of Insurance. Thank you all for coming today. We're tickled to death to see a crowd either equally as large as our last one or maybe even larger, and we hope to have the same really good exchange that we had the last time as well.

As you know if you were here at the last meeting, we did have the court reporter do the actual finished project of the meeting that afternoon, and I told several of you or I think we told you as a group that we would make this available if you wanted a copy of it. We've had several people ask. One thing I didn't know when I made that statement, since this is a court reporter process, there is a charge for this. It is not free. Even the Department can't provide it, I mean we can't copy this and give it to you or anything.

If you want one of these from the last meeting, you're welcome to it. Go ahead and either contact me or Tina with that request and we'll pass that on to the agency that provided this. We think that it would be about $100, FYI, and it's based on the amount of time that they spend actually taking the notes during the meeting, so it's a time issue. I wanted to get that out of the way right of way.

I'm going to go ahead and introduce the folks who are up here with me, since I was so rude

and forgot them the last time until about 20 minutes into the session.

To my right here is Tina Korty, who is from our Legal Division at the Department of Insurance. One of our very good attorneys who deals a lot with medical malpractice issues, so this is a topic that she can certainly relate to.

To my left is Jerry Malooley, who many of you already know who has a very long background in health related issues, worked with the State Chamber of Commerce on health issues for many years, and is currently working on health policy at the State Personnel Office.

We are thrilled to have both of these ladies here today because they can really add a lot to the conversation, as they did in our last meeting.

The information on the agenda, I do want to just go back over quickly the topics that Senate Bill 372 stipulated that we were supposed to look at. The main topic, of course, is preauthorization or precertification procedures, and, then, if we have time we'll address the other

issues. I think again the Legislation was probably focused on some sort of standardization in terms of explanation of benefit forms, ID cards, questions regarding the timeliness of filing of claims by providers to insurers and HMOs, and then lastly what kind of format or timeline would there be for notification to an out-of-network provider for reimbursement rates on a preauthorized service or treatment by that insurer or HMO.

So it's a pretty broad range, and I don't think necessarily that they expect us to come up with wonderful answers in all those categories, but certainly the preauthorization and precertification was the main issue.

We had some very good comments at our last meeting from the HMO world, from the insurer world and certainly from the provider world. We're very fortunate today to have even more folks, I think, from the provider world with us who can give us some other parts of this issue that maybe we didn't pull out of our last exchange. So we're glad to have that input today and hoping that we

can again, you know, collect as much understanding and information about this topic as possible.

One of the other issues that popped out, pretty significantly in the exchange that we had last month was, there seems to be a clear delineation between the preauthorization, precertification issue --

(Brief interruption from the Aetna people on the conference phone.)

HEARING OFFICER CUTTER: One thing you guys are going to have to do today is you've got to come up here when you talk because the court reporter wants to be sure she captures everything accurately, and the acoustics in this room aren't all that great.

Aetna, would you please identify yourself so the folks in the room will know who you are, since you sound like my mother over in the corner, you know, that third eye in the back of her head telling me what I'm doing wrong.

MS. SULLIVAN: Corie Sullivan, counsel for Central Region.

MS. STEPHAN: And this Bonnie Stephan,

counsel for North Central Region. Hi, everyone. We appreciate your patience while we attend via phone.

HEARING OFFICER CUTTER: Thank you, ladies. They're with Aetna.

One of the principle things that popped out of our last meeting, as I was saying, is there seems to be a clear delineation on preauthorization, precertification issues between the HMO world and the insurer world, and obviously for those.of us who deal with insurance on a day-to-day basis, we understand that, but maybe not everybody in the room would it be that clear about why that would happen.

The primary reason for that is that insurers will in many cases rent networks of providers, so the relationship with that provider is not at the same level of intimacy as it is on the HMO side of the fence. The HMO providers and contracts that they agree to are a much closer relationship with the HMO entity than it is in some cases on the insurer side.

Because of the rental issue, I think

that's probably what opens the door a lot of times to some of these other things that pop up that may not necessarily be a result of that same process in the HMO world.

So maybe we can take some pointers from them but we're also looking at -- and I spent hours and hours and hours with one click of my mouse on a web site and pulled up some information from these other states. I didn't spend hours and hours, I'm just joking -- so that we have some sense of this same issue and how it's being addressed in other states so that we can learn from what's already out there: Is it good? Is it bad? You know, is it helpful? Is it not helpful? Should we even consider it; that sort of thing.

Tina is kind of walking through that right now so that we'll have some better basic criteria to give you as we talk this afternoon.

I think because the providers can give us a perspective not only of their world but also how it impacts the patient in many cases, I want to start with the provider issue this afternoon. I know there are several providers here in the room

with us that weren't here at the last meeting.

Michael, did you want to start us off today? Is there anything additionally from what we exchanged at the last meeting that you want to bring to the table?

MICHAEL YODER, CEO
SOUTHSIDE FAMILY MEDICAL GROUP

I am Michael Yoder, Southside Family Medical Group.

In our conversation last week or last month rather, we concluded with the concept of is there some way to get a uniform precertification, prior authorization process. You know, one of the problems we have as a family practice office is it's hard for us to know which policies even within one insurance company, require pre-cert, prior-auth referral, it's hard to know that.

Out of this last meeting, we did have a meeting with Anthem that gave us their web site, that gave us a nice fixed stack of information that we can thumb through, but it's still such a big stack.

Again, coming back to the idea of how can we simplify the process? I'm not sure I have a good answer for that because it is a big question, it is a hard question to answer.

Some of it I have to look back in my notes. I wasn't prepared to talk quite this soon, but one of the ideas was, if I recall -- help me out here, is there some way to --

HEARING OFFICER CUTTER: Have a list of what --

MR. YODER: Well, exactly, to simplify it a little more instead of -- have a clearing house, one central clearing house that we can go to instead of going to Anthem web site, Aetna web site, United Health Care web site, M-Plan web site. You know M-Plan is pretty clear cut, you need a referral.

But instead of going to these places, is there one central location to which we can go? If we can do something like that through the State, that would be wonderful.

I want to commend the State here because there's a new web site for our doctors regarding

prescriptions and where patients were getting prescriptions. That is a wonderful tool, and if there are doctors in this room that are not aware of it, check with your association. It's a wonderful tool to find out which one of your patients is abusing their medications. So I'll just throw that out there.

HEARING OFFICER CUTTER: Thank you, Michael.

Did you want to come up, Bernie?

DR. EMKES: Just as a word of advice, be careful coming on this side because there's two cords.

BERNIE EMKES, M.D.
MEDICAL DIRECTOR
ST. VINCENT HEALTH

Good afternoon. Thank you, Carol.

I'm Bernie Emkes, I'm a family physician by training and a medical director at St. Vincent in the managed care department. As such, we get to hear about a lot of issues with many, many insurance plans and many of those trickle up to

me, only because I'm kind of the place they trickle to.

I have with me today, Lori Mills, who is one of our practice facilitators, managers in our network and I'm going to ask her if possible to come up after me to talk about some very specific issues.

I would just like to add to what was said there, the problem that we see, I think, from an insurance plan issue has to do with insurance plans really not being the vendor of last resort. Several of the large insurance plans have actually farmed out radiology, particularly precertification processes to vendors, and the vendor then is, in my opinion, acting on behalf of the insurance plan.

In many cases there seems to be a bit of finger pointing going back and forth: Well, we didn't tell them to do it that way; well, we're doing only what we were told. And that leads to some real confusion on the part of physicians, particularly as they try to take care of patients in their offices who have some level of acute

medical problem, and I use that term kind of relatively.

As any of you in healthcare know there are emergencies. I have a spear sticking out of my chest, that's an emergency. I have a gun shot wound or an acute laceration. Those are acute emergencies.

There are also urgent situations where a patient presents with increasing symptoms over a period of time and they are now at the doctor for a reason. They're sick enough. They believe they need medical care at that time. That is slightly different than an emergency but not a lot different, and that's a problem.

And, then, the third thing is elective, where you come in with a headache and we decide you need a cat scan and we can do that tomorrow or we can do it a week from Friday, and probably it's not going to make a huge difference when that gets done.

So I'd like to differentiate between those three different kinds of patients. I think the problem that we see in our network, and I think

Lori will speak to this, is the urgent patient. Emergencies usually end up in the emergency room, and many of the companies don't even require pre-cert authorization for cat scans or MRIs, or whatever, if they're done in an emergency room.

On the flip side of that, if the same patient happens to be seen in a physician's office, which is really a much more cost effective way of taking care of the patient, then the pre-cert is required and there's always that gray area that seems to require a lot of time on the telephone, use of resources, and et cetera, et cetera, et cetera. I think that's what this committee is designed to try to look at. So that is my first comment.

My second comment has to do really with the potential harm to the patient. Lori will speak to this I think very effectively. But in those urgent cases where a patient comes in and they have swelling in their right lower extremity, and we, as a doctor, believe that they may have a blood clot, but the health plan requires precertification for the ultrasound to prove or

disprove that blood clot, and then the health plan tells us they have between four and 24 hours to make a decision about whether they are going to give you that authorization, that is a problem for practicing physicians. And I think it's a problem for the citizens of Indiana as they are trying to protect themselves from a worsening condition, i.e., if that blood clot is there and breaks off and goes to the lung, while the insurance plan is deciding whether or not the test is needed. I think that's a problem, and I think everyone in this room would probably agree with that.

So in my mind the bigger question that we need to think about is, as a group and maybe as a legislature, how do we differentiate between acute, semi-acute, and elective, and the processes that need to be in place.

I wrote two documents and I will leave them with you for your edification. I don't want to necessarily read through them because it would take most of the time that we have here today, but I do think that the issue of the art of medicine versus the science of medicine is to some degree

what is at stake here.

Yes, there's a lot of science in medicine, but when I go to Dean Holden in the past or Dean Brater today and say, "What percentage of things that doctors do have absolute evidence to support what is being done?" The answer is always less than 50 percent.

Yet, radiology pre-cert processes are defined as a 100 percent process, which makes no sense to physicians who see patients every day and try to take care of sick patients in their office.

So those would be my comments at this time. I'd be glad to answer any questions now or in the future, after Lori comes up.

Lori, you want to come up and talk about some specific cases that you had that have been difficult.

LORI MILLS, R.N.

Good afternoon. My name is Lori Mills. I'm a registered nurse. I'm a regional practice administrator and I'm a consumer of healthcare, as

all of you are as well.

I don't think anybody realizes, unless you're actually at the desk trying to provide quality healthcare for our patients and families, what the process is to get a precertification to the facility that is then going to take care of that patient. It's very time consuming. It's very frustrating, and well-intended, dedicated staff try repeatedly to penetrate the obstacle that completely bombard us and keep us from achieving our goal. Sometimes we can be on the phone for 40 minutes and plus 40 minutes trying to get to someone only to be met then either with, oh, you're in the wrong district. I need to transfer your call. Repeatedly that will happen. We will get ended calls and our destination is always uncertain. It's very time consuming. It's very costly.

From a regional practice administrator point of view, I have to look at that cost. I have to look at how much is it costing for that staff member to constantly be on the phone, on hold, when they could be doing something else,

going for other patients to put them in exam rooms so the physicians can do what they do best.

So I have to look at all of those measures and say this is very frustrating not only to the patient and family, but certainly to the staff as well.

I applaud Dr. Yoder for saying that no two companies are the same, and not only that but no two companies within the company are the same, and you'd better get a name because you may have to go back to that person, and we have many times, but I talked to Susie and Susie gave us the pre-cert number. I'm giving you the pre-cert number.

I'm sorry that pre-cert number doesn't register and we don't have a Susie here.

I can't tell you how frustrating that is because in the end you will get that bill and you will have the balance to pay.

We try to do our best, sometimes it's just not good enough, and that's a very, very sad situation for all of us, and we hate that as much as you hate receiving that bill.

As a nurse I must say that recently we

have had several patients who have needed stat procedures. Immediate, within an hour, would you say, Dr. Emkes, is reasonable for stat? When we attempted to make the call -- we had one lady who actually had a very high fever and abdominal pain but she had been going for four or five days and she said, you know, no, I don't want to go to the hospital. Do everything you can. So we needed a CT scan. Called the company and they said okay, that stat authorization, if it comes through, will take between four and 24 hours. Four and 24 hours for someone who has fever and abdominal pain.

At the same time what I didn't know was happening at another nursing station in this particular practice, there was a head injury of a young man who had fallen off his skateboard, hit his head, and a day later was starting to have visual problems and vomiting. Doctor ordered a cat scan of the head, and, again, same company, four to 24 hours.

That's fine, you think from a payer view. If you are the parent of that child or the patient, in either of those cases is that acceptable?

Absolutely unacceptable. And as a healthcare provider I'm saddened and embarrassed to think that I have to deliver that message to those people.

So it happened to be that was a Friday evening at four o'clock. Well, when I said to the person, so you're wanting me to stay a minimum until 8:00 p.m. this evening, and have my employer pay me overtime just so I can make sure that this person is going to be able to have a pre-cert to get these tests done.

They said, you know what, send them to the emergency room.

I said, is that really cost effective? I'm really trying to do my job to help you, as well as I'm trying to do my job to help us, and to go to the emergency room is completely counter intuitive to what we're all here to do as healthcare professionals and cost effective managers.

They said, you know what, this is the best we can do, four hours. I want you to know I stayed. I stayed until five until 8:00. I called

back, and we got the referral. I was able to call that person. We did get them in for the test. We got the young man in for the cat scan of his head as well.

But 24 hours wasn't going to be up Saturday at four o'clock because Saturday and Sunday are weekends. It was the next business day, which would have been Monday evening at four o'clock. That again is totally unacceptable. It is absolutely against everything any of us went to school to be educated to do to provide quality healthcare. I'm very sad that that situation is very real and it's not just our practice, it's yours too.

As a consumer I can tell you that we have someone in our family who went for a general health screen, and at that screen it was determined that he has a nodule in the upper left lobe of his lung. The recommendation from a very wonderful physician/radiologist said he needs to have a P.E.T. scan. That came back to his physician. We called the insurance company. The P.E.T. scan was denied. They said he needs a cat

scan at the least. We called the radiologist locally and he said, you know what it may not be differentiated. You really ought to go for the PET scan. We called the company back. This time the physician called. Again, the physician was denied the P.E.T. scan. We went ahead and obliged. We did the cat scan. Not only does he still have the upper left lobe nodule he has two in the left low basis as well.

Could that be differentiated between on the cat scan; I'm afraid not. They said, I'm sorry we can't differentiate anything. You need the P.E.T. scan.

So once again the doctor called, and he said, now we've cost you a lot of money, are you ready to move to the P.E.T. scan? We have that scheduled August 26th. Is there a price on family stress, family sleeplessness, family anxiousness; there's no price on that, not at all.

I'm sorry, but that is again another situation; very real now, very real, but I always felt the realness when I had to report the same kind of misunderstanding to the patients. That

the insurance company would not listen to what it was that a very capable, competent, educated, medically caring, physician made a judgment, a clinical judgment, that you, some of you, need a specific test, but unfortunately someone other than a physician is making the decision with no hands-on clinical exam. They haven't touched anybody. They haven't seen the chart. They have no past history to go by. They have nothing. They have nothing to make that clinical judgment on the other end of the telephone, and I'm very sorry that it's come to this in many cases that those are the folks that are making those judgments.

So on behalf of St. Vincent Health and our practice, thank you for allowing me to speak.

HEARING OFFICER CUTTER: Thanks, Lori.

Any other providers in the audience that would like to come up and address this issue or maybe give us any different perspective on what we've already heard.

MR. YODER: I'd like to.

HEARING OFFICER CUTTER: Absolutely,

Michael. Come on, come on.

MICHAEL YODER, CEO
SOUTHSIDE FAMILY MEDICAL GROUP

Again, Michael Yoder, Southside Family Medical Group. I just want to make a direct recommendation to the committee and hopefully this is something that can be considered and presented to the Legislature. At the end of the last meeting we talked about the gatekeeper. You know it wasn't that many years ago when the primary care doc was talked about as a gatekeeper. You went to the primary care doc, everything was to go through the family practitioner, the pediatrician, the OB-GYN, your primary care doc was to be that gatekeeper to determine what needed to go to the next level, and we look to the primary care doc, they're the ones who are trained in that area.

At the end of the last meeting we talked about the possibility -- we brought up the idea of, you know, how many of these prior-auth, pre-certs are actually turned down, what percentage, and it was acknowledged by our payers

that they are a very small percentage.

On the other hand, and I do understand our perspective, it was also acknowledged that when we eliminated or when they eliminated the prior-auth, pre-cert requirement, they saw an increase in cost as providers start over-utilizing, in their opinion, those services.

So the recommendation was made by -- forgive me I forget your name, Doctor -- but by one of the doctors that we waive maybe some of those requirements, that we identify doctors and we monitor doctors that are over-utilizing through, maybe their billing records.

I would like to suggest as a concrete recommendation or a concrete proposal is that maybe we require prior-auth, pre-certs for new doctors coming into practice for the first couple of years, after that, waive it. You can monitor them through your billing records. You're going to get the plans as payers. You can see what the doctors are doing. Waive it after that, let your doctors do their job.

The doctors are there to take care of the

patients. They're not there to work as -- nine times out of ten, 99 percent of the time when the doctor orders these tests they get no reimbursement, they get no revenue from those tests. So that really is not an issue. The doctors are looking out for the patient.

So I would make a recommendation that we waive the prior-auth, pre-certs and monitor through billing after maybe some brief introductory period.

Thank you.

HEARING OFFICER CUTTER: Thank you, Michael.

LORI STONECIPHER, OFFICE MANAGER
ACADEMY ALLERGY ASTHMA & SINUS

Lori Stonecipher, Office Manager for Academy Allergy Asthma & Sinus.

At the last meeting we talked about wanting to have some examples of where we had spent the time and energy in getting prior authorizations and then only to come back and find out that their insurance company has denied the

service, even after they have gotten the prior authorization and gone through that process.

I have brought with me two examples here. I de-identified the patients on these, and I'd like to give them to you for the official record.

One was a sinus CT scan. One is a MRI. Again, the letter says, we have determined that the requested services will be provided, gives you an authorization, and then I have attached to the back where it says: "Dear patient, Your insurance carrier has notified us that payment on the above account has been denied." Even in regard to the prior-authorization.

I wanted to give you guys these examples to have, just to show you that even though you're going through all of this, it's still being denied and payments are still not getting paid to those providers.

HEARING OFFICER CUTTER: Thank you, Lori.

I know one of the things we talked about last meeting was in terms of denials of the pre-certs. In terms of percentage there weren't that many of them. One of the things that Tina

and I were talking about coming over today is, I'm hoping that we will have either somebody from the HMO world or somebody from the insurance world who can say, you know, we went back and we kind of looked at this and these are the circumstances under which most of those denials occurred. Did anybody do that?

LORI MILLS, R.N.

The reason that you may not be seeing denials in a huge bulk is, because as my last example explained, we were denied getting the tests that we wanted, therefore we went with a lesser test or a test that we did not originally want. Therefore we did that, now we can finally have that. So you're not going to see a denial. But what you don't know is, we were denied by phone and that's where it is. It's on another level; you're not seeing it.

HEARING OFFICER CUTTER: Thank you.

Yes, there's that piece, and there's also the piece of when it does get to the insurer or

the HMO level, what are the main reasons why there are denials. I mean in the cases that you gave I'm presuming that a cat scan is cheaper than an MRI?

VOICE: Correct.

HEARING OFFICER CUTTER: I don't know by how much. I don't know if there's a huge gap in cost or not. But I know my husband worked on scan equipment for many years on mobile scan equipment before all the hospitals got their own, and what you use cat scans for is very different than what you use a MRI for, in terms of what you're trying to find and what you're trying to see.

Do you think in the insurance world there's no understanding of that distinction between these tests for these folks that are doing the precertification? I mean, have you ever had that conversation?

BERNIE EMKES, M.D.
MEDICAL DIRECTOR
ST. VINCENT HEALTH

Yes. I'll put on another hat when I

speak.

Bernie Emkes, again.

Past medical director of our physician hospital organization, medical director of health plan, so a little different role but nonetheless some experience.

I believe that there are processes in place and there are algorithms that people should be following to decide which test is the best, which test may give you the most information.

The problem that I see is that (A) the people that Lori is dealing with on the telephone may have an algorithm in front of them, but, you know --

I explain healthcare in one of two ways, and my boss is sitting here so he'll know this, healthcare is either a thousand piece jigsaw puzzle with ever changing borders or it's an OWA, Other Weird Arrangement. Now, if it isn't the thousand piece jigsaw puzzle, which has been created by a pre-cert process, every patient that walks into my office is an OWA. There is no one-patient profile that you see, Dr. Yoder,

Dr. Patterson, or anybody else. Every patient is a little bit different.

The other point I wanted to make and didn't earlier had to do with pharmacy. I think there's some differentiation that needs to occur and this will be controversial because I'm going to make it sound like primary care physicians aren't specialized enough, but one of the problems we see -- we employ a lot of sub-specialty physicians at our hospital, and when it comes to the pharmacy side of precertification there are just as many problems there as there are on the side of radiology; probably more, actually, because there's even more plans, and you're dealing with the Medicaid programs, plural, each of which has a different formulary, et cetera, et cetera, et cetera.

But the dilemma that I run into with our specialists is they are kind of the court of last resort. You know, the asthmatic patient who's been to a primary care physician, whether it be a pediatrician or a family doctor, they are not being well controlled. They may have even gone to

an allergist. Now, they're going to a pediatric pulmonologist, and the pediatric pulmonologist says this is the medicine I need.

Why do I need that?

They failed these over here. And I am now at my wit's end and I don't know what else to do for this patient. This is what they need. Only to be told, no, you can't have that because we would prefer you take two of the old ones that didn't work and combine them and use them at the same time and, then, see if that works before you provide the best treatment that you think is right for the patient.

So there are so many permutations of this that it's very hard to get the answer, and is probably why there's a study committee. But I think this is just the tip of the iceberg of the problems that physicians deal with every day. Like I said, I don't personally deal with these problems and that's why I asked Lori to come because she deals with these in relationship with her physicians every day.

Again, I'm happy to try to answer any

questions, but hopefully that clarified a little bit of what we're talking about.

HEARING OFFICER CUTTER: Thank you, Bernie.

In addition to radiology and meds, is there any other category of treatment or services or issues that predominate the problems that we have with preauthorization, precertification?

DR. EMKES: I think that's a very question.

I think what was going through my mind was referrals. Referrals to the appropriate physician to manage a particular patient.

Dr. Yoder mentioned the state registry program for pain medications primarily, but it's used for all medications. What we as physicians are interested in --

MR. YODER: I hate to interrupt, but I'm not a doctor. I'm the Chief Executive of Southside Family Medical. For the record I'm not Dr. Yoder.

DR. EMKES: Thank you. Sorry.

BERNIE EMKES, M.D.
MEDICAL DIRECTOR
ST. VINCENT HEALTH

The point is well made, the registry is hugely helpful and initially that was to be used only by the State Police Department.

Fortunately, the Medical Association through ISMA and the Indianapolis Medical Society went to the State and said, you know, this is nonsense. Doctors are the people taking care of these patients. How do we not have access to this type of information. We are the ones who can make a difference on the front end. So these are the kinds of programs that I think work.

I like the idea of a uniform process, a uniform way of dealing with these kinds of situations. I think that's a wonderful idea, but I also think that there may need to be, and you started to speak about that, stratification, you know, how do we identify who is properly using and improperly using these costly resources that we all agree have to have some level of management built into them, but then how do we define who

needs to go through these seven hoops as opposed to who needs to go through one hoop or two hoops.

HEARING OFFICER CUTTER: Thank you.

Anybody else?

DR. PATTERSON: Yes.

HEARING OFFICER CUTTER: Come on up, Dr. Patterson.

DAVID PATTERSON, M.D.
ACADEMY ALLERGY ASTHMA SINUS

Thank you, Carol.

I'm Dr. David Patterson. I'm a private practice allergist. I want to speak to something that Bernie brought up because it's at the heart of our practice. You know, as a specialist people come to see me with really complicated problems. I'm like Bernie said, I'm kind of the guy of last resort, and people come to me and say, you know, I've seen Dr. X, Y and Z, and they couldn't help me. They tried but they couldn't help me, so you're it. So that puts a lot of pressure on you as a physician.

Many times I'm able to make a diagnosis

and suggest a treatment option for these people who have some unusual problems only to be told by the insurance company I can't do a test, I can't do a treatment, I can't do a medication, it's not covered, it's not FDA approved, it's not on the formulary, it's not this, it's not that, and that's a real problem.

What medicine is becoming is, it's becoming a system where if you have a common straightforward one problem that fits an algorithm that we have in medicine, which isn't a lot of us, you're in good shape.

But God help you if you've got a problem that is outside of the norm or you have several problems that interact with each other. We don't have a way to deal with it because we don't have a set of algorithms.

We've made medicine a series of algorithms and it's not. People are not a series of algorithms. They are a very complex biological organism that respond differently to different treatments and have various diseases and have things in combination. The system gets infinitely

complex really quick.

There's nothing more frustrating to see in my business than simply seeing a patient in front of you that has an immunodeficiency. They've been sick for years. They've gone from doctor to doctor and they've been on countless antibiotics, and you have finally figured out what you think is wrong with them and you're ready to suggest a treatment and the insurance company says, "We're not going to approve that. We can't approve that."

It's not just a prior authorization or precertification. We're not going to pay for it period. We're going to practice medicine and tell you what this patient should get and not get.

So we've really got to -- when we enact all these regulations, we're just hurting ourselves because we're all going to be patients sometime and we all have loved ones who have complex problems, and it really does come back around to bite us in a really big way.

I really see that on the specialist side because I deal with some really arcane, outside

the box type of stuff, and I use a lot of things that are treatments that are kind of last resort; maybe they're off label, maybe they're not FDA approved, and we explain the risk and benefits very carefully to patients, and a lot of those patients respond very well, it changes their life for the better. But it doesn't fit in a nice neat algorithm and frequently it is an all out battle with the insurance to get things paid for.

So I think you've seen a little bit in the media because you've seen some cases highlighted in the media where people have had cancer, especially children, we all have compassion for children, and these children had cancer that hasn't been treated before and they want to try some experimental drugs that's not FDA approved, and the company with the drugs says, no, we're not going to give it to you; the insurance company says, I'm not going to pay for it; and that's created this big uproar.

But it doesn't just happen to people with terminal cancer, it happens to people with chronic diseases who don't have a terminal disease

necessarily, and yet they're trying to get some sort of treatment and the insurance companies are saying, no. We're not going to give you that treatment. We're going to deny that.

So, you know, we've really got to think about what the end process is here, and if the end process is to help patients, we've got to make these regulations less burdensome or we're really going to have some problems.

HEARING OFFICER CUTTER: Thank you, Dr. Patterson.

Anybody else?

I think we've heard both sides of the issue with the providers. Thank you very much for coming today and opening up some other things for us that poor Michael wasn't able to carry or Dr. Patterson wasn't able to speak to last session just because of the areas that they are pretty much dealing with on a daily basis.

So we have said is there a possibility to define those folks who maybe should be monitored more closely in terms of providers. I think too Michael's point makes some sense.

I am going to ask for -- I know there's some HMO people in the audience. Are there any insurer reps here today besides Aetna?

I think it's probably appropriate for us to ask Aetna to speak to this issue since they are an integral part of our insurance world here in Indiana.

One of the things that we probably need to put on the table right now, and I know this impacts the providers, but I don't know if they realize to what extent it probably impacts them.

There is a difference in insurance plans between an ERISA plan and a fully-insured plan. What we are talking about today is not going to touch ERISA plans. So a lot of the carriers, like Aetna and Signa that deal primarily with the larger employers and do a lot of ERISA plans, whatever we say, whatever we recommend to the Legislative Council will ultimately not impact them at all.

In the State of Indiana, probably close to 60 percent of the people who are insured by group insurance are under ERISA plans, not fully-insured

plans, which in my opinion helps complicate the circumstances that we're trying to cope with. And I don't know, are there any lawyers to tell me is there any way to get around that, but I don't think there is. State law just doesn't ever trump Federal law, so we're sort of glued to that, I'm afraid.

Aetna, are you prepared to talk a little bit about your side of the issue in terms of the preauthorizations, precertification.

BONNIE STEPHAN (via telephone)
AETNA

Hi, this is Bonnie Stephan with Aetna, and I hadn't planned on talking, but are there no other insurers or health plan representatives there in the building?

HEARING OFFICER CUTTER: They're hiding.

MS. STEPHAN: They're hiding.

You know we appreciate the opportunity to talk and recently over the last several years Aetna has reduced the amount of items that must be pre-certified, and certainly I don't know who the

physicians are that we're working with that we're not getting responses to them fast enough.

I can only speak to some of the things that we have in place. That if the physicians believe it's urgent, they should go ahead and provide the care. So, you know, I can't speak with all the plans because I don't know what specific problems they have.

Would it be easier on everyone if there were no rules? Probably, yes. And would that spiral medical costs, absolutely. So I'm not sure that there's any easy answers, and I think that's why we like to attend forums like this to understand a little bit better and, you know, try to come to a resolution that everybody can live with.

CORIE SULLIVAN (via telephone)
AETNA

This is Corie Sullivan, and we do see ourselves as providers in the healthcare operation, so as Bonnie and I were talking as the meeting was going on about what our

preauthorization requirements are and as she stated earlier it is much more limited than it had been previously.

And one of the questions I had was, are you physicians seeing an increased difficulty in precertifications, is it different than what it had been previously?

MS. KORTY: Everyone in the room is nodding their head yes to that question, they are seeing increased difficulty in getting preauthorization.

DR. EMKES: But not necessarily Aetna.

MS. SULLIVAN: Because there are more items to be certified or because it's a different process?

MS. KORTY: Anyone want to address that?

DR. EMKES: Just so you can hear me, this is Dr. Emkes again, Bernie Emkes. With Aetna, particularly, the issue is not the pre-cert process.

However, the experiences we've had have to do with what your company considers investigational and experimental and therefore not

payable by the plan after the patient has had the test already performed. It is the expectation of Aetna, evidently that we understand everything that you consider non-covered, non-investigational or experimental and notify the patient ahead of time in order for us to then, shift that cost to the patient.

That is the issue that I've seen primarily, and I'm getting a lot of head shaking from some cardiology folks here in the front row here. So that has been our issue, and if you want specifics I don't know that I want to share that in this big room, but I'd be happy to share my phone number with you and you can give me a call and we'll privately talk about those tests that Aetna is the only company that do not cover nationally, to my knowledge, such as certain blood tests and certain other cardiac testing.

MS. SULLIVAN: Okay.

MS. STEPHAN: And this is an issue too?

DR. EMKES: I would say this is more ongoing. I know that actually your company has had discussions with the American College of

Cardiology and that your company has had discussions with me personally, I know, about the issue and how we can maybe help resolve that and come to some mutually agreeable situation but we haven't moved very far.

MS. STEPHAN: We can follow up on that and see where that stands. Thank you.

MS. KORTY: To the Aetna people, this is Tina Korty, from the Department. You weren't listening in on our last study committee meeting but one thing that the providers pointed out in that situation is that -- or at least they believe everything that is being saved on your end is being spent in their offices for added staff to go through the preauthorization procedures, and no one at the last meeting was able to provide us with any data on the savings from the insurers end, and I was wondering if you have any information you can share with the room on that?

MS. SULLIVAN: No.

MS. STEPHAN: Tina, if I can restate, it's a little bit difficult to hear, are you asking us for data that demonstrates the savings due to

precertifications?

MS. KORTY: Yes.

MS. SULLIVAN: I don't have any handy.

MS. KORTY: Is it something you could provide to us before the next meeting?

MS. SULLIVAN: When is the next meeting?

MS. KORTY: September 10th.

MS. SULLIVAN: This is Corie Sullivan speaking. I'll see what I can find out what's already captured and try to make those determinations. There's staff physicians that make clinical policy determinations and those clinical policies are on-line, and you can access those.

MS. STEPHAN: I think what you're asking is, can we document savings on the variety of processes that you're having to go through and what happens to those savings, do they translate and reduce premiums; is that what you're asking?

MS. KORTY: Basically what we're asking, are there savings, and if so, can you tell us what those are.

MS. STEPHAN: Okay. You know I would

imagine there are savings and I will have to see what I can find, okay.

MS. KORTY: Okay. And that invitation goes out to anyone in the room, if you want to document the savings from preauthorization or document the cost to your practice of having to go through the preauthorization procedure.

Our task for the Legislature is to gather information, and the more information we can gather, the more informed this decision will be.

HEARING OFFICER CUTTER: Mr. Willey, that goes for you too.

MR. WILLEY: We will provide that information at the next meeting.

HEARING OFFICER CUTTER: I am going to pick on the HMOs for a minute because they were so helpful last meeting and, Peggy, you're here, Holly is here, you guys made it fairly clear that in terms of the preauthorization, precertification process your list of those items that really fall into that category has been substantially reduced over the last few years so that you don't have, maybe, as many of those on your side of the fence

as the insurers have; is that a fair statement?

HOLLY KING
M-PLAN

I'm Holly King with the M-Plan.

Yes, Carol, I think that's a fair statement. I think though that the real key is that with M-Plan, and I know with Advantage, and I think PHP, the final decision is left with the physician, so the provider makes that decision.

Now, there are certain things that have to pre-certified at the plan level. You had someone call me yesterday about one that came up and the end result, what I found out when I looked into it was that the particular drug that they wanted to use was not FDA approved for that purpose. So we just had to have the provider provide the additional information to justify that they needed that, which had already been faxed, but, you know, that's a safety thing.

But I think in general and I think you mentioned last time Mr. Yoder that you didn't have issues with the plans that work through

St. Francis Regional or --

MR. YODER: St. Francis Hospital.

MS. KING: -- provider networks. So I don't know that these aren't relevant. I would like to hear if you do have issues.

MR. YODER: Actually, we are not a plan participant, we dropped them.

HEARING OFFICER CUTTER: Do you ever see like the denials on the preauthorization or precertification? I mean, I know yours are few and far between because of the way you leave the call ultimately to the physician. But when there are, can you give us any idea why, is there a common reason for a denial or is it going to be because there's so many different circumstances you're going to depend on the patient, and the condition, and the diagnosis, and the treatment plan, and all that sort of thing.

MS. KING: And I'm not a clinician so I can't speak 100 percent sure, but I would say that most of the time the reasons for our denials are not clinical or medical.

They are administrative. The situation I

brought up last time where somebody -- maybe they're on COBRA and they didn't pay their COBRA premium. Well, we have to cover them. We have to give them the 30 day grace. So they may be getting treatment in there and when the bill actually comes in, they never paid their premium so their coverage has lapsed. We had no way of knowing that when they were getting treatment and the doctor didn't have anyway of knowing it either. Presumably the patient would have known that they didn't have coverage.

But that probably is the most common situation where we have a denial is where somebody wasn't really eligible for coverage and we didn't know it at the time.

HEARING OFFICER CUTTER: Thank you, Holly. So it's more from an administrative perspective in your world that you guys see that happening than from any clinical issues?

MS. KING: Yes.

MS. MALOOLEY: May I say something?

HEARING OFFICER CUTTER: Yes, Jerry. You want to come up.

JERRY MALOOLEY
STATE PERSONNEL OFFICE

Jerry Malooley. I'm going to wear my State Personnel hat today.

We have had many employees call us and say that the prescription they were on is no longer on formulary, et cetera, or, you know, and how do we know this, and now I have to bother my physician for maybe a less effective medication, et cetera, or go through a long process.

That's one issue that we would like to understand why that happens in the middle of the year, and why whatever we start out with, unless there is a recall or something like that, why for one year our patient can't be on the drug -- why are things removed just -- it looks as if -- to someone like me, it's arbitrary or economic or something like that.

The other thing is, if something isn't FDA approved, do you as health plans ever look at the specialty or sub-specialty societies to find out what is truly effective in their practices?

For example, I remember Tegretol as an

anti-convulsant but it's also used for pain. I don't know whether you are actually going to wait to find out if it works for pain and the FDA approves it, or if enough physicians have used it for pain and saying, yes, you know, as a neurologist this is what I do and it works very effectively.

We would like to understand from a health plan standpoint, we're self-funded, but still we would like to understand how that happens to the pharmacy formulary.

HEARING OFFICER CUTTER: Can anybody answer that one?

DR. EMKES: Yes.

HEARING OFFICER CUTTER: Yes.

BERNIE EMKES, M.D.
MEDICAL DIRECTOR
ST. VINCENT HEALTH

If the HMOs won't, I will.

Bernie Emkes again, I'll put on my third hat. I used to sit on a pharmacy and therapeutics committee for one of the local plans.

I think there's multiple answers to your question. One, drugs may become generic during the middle of the year. So where Prilosec was covered before, now it's become generic or it may go over-the-counter, that's the second reason.

If it goes over-the-counter, the plan will probably not pay for that on prescription because it's now available to be purchased over the counter.

There may be contracts that the plans have. These could be national plan contracts or local plan contracts and if they can't come to an agreement, there may be a change in formulary because the contracts have changed, expired, or are non-renewed, or are chosen by one party or the other not to renew.

I'm trying to think if there's a third reason. It seems like there's another couple of reasons but those are two of the major reasons I think, and since I didn't see anyone coming up from the industry.

HEARING OFFICER CUTTER: Thank you.

John, can you talk about this at all?

MR. WILLEY: Jerry, as far as being the state funded administrator, which is what we are and we're happy to talk about it, as you know you're self-insured, so you're making a lot of those policy decisions regarding the formulary and what drugs are on it.

So, again, I think that's a better question to take on-line. If you have specific questions with the State account situation, instead of ERISA, we'd be more than happy to look into that.

HEARING OFFICER CUTTER: We have fully funded also. But I think that's a credible issue on the fully insured side. I don't think that's just specific to the self-funded plans. We hear complaints about that from consumers all the time.

You know, Mike, I've tried all these other things and they didn't work and so my doctor gave me this one medication, which thank goodness is working, and now I find out that my insurance plan isn't going to cover it because it's not on the formulary any more.

So that was helpful for us to understand

and know. I hadn't even thought about the contract changes.

I don't know that the generic issue comes up as often as maybe some of the other reasons why plans will take medications off of their formulary, maybe the contract issue is more common in those circumstances.

DR. EMKES: You would be surprised though the number of patients where the brand name supposedly works perfectly but the generic doesn't.

HEARING OFFICER CUTTER: Yes.

DR. EMKES: I can't explain that, so don't ask me.

HEARING OFFICER CUTTER: Because it's my understanding that there's not supposed to be any pharmacological distinction; right?

DR. EMKES: Plus or minus a very small window.

HEARING OFFICER CUTTER: Okay, okay.

DR. EMKES: There is some allowance but it is a small window.

HEARING OFFICER CUTTER: Okay. And I

think that's fair because I think all of us would have to agree that with the advertising that takes place in major media these days, you know, in print, on television, on the radio about these medications and how wonderful they are, not that they're not wonderful, but you know people hear that.

In fact, my secretary was saying to me last week, we were talking about some health condition, and she said, I don't think I've ever heard about that.

And I said, well, how can you not have heard about it?

And she said, oh, when that sort of information comes on, I turn off the radio or the TV, or I just mute it or something, because I don't want to hear it, because I'm one of those people that if I hear it, I think I've got it. So I've just been a whole lot healthier if I don't hear about it.

So that's her way of coping with it.

Well, the reverse of that is also true. There are many of us who, you know, hear about

some medication or we think we have some condition or disease or the symptoms seems similar and all of a sudden we self-diagnose and we know we just have this issue and we go to our primary care physician and we say, you know, I think -- well, I did that to my doctor not too long ago. I said something about carpal tunnel.

And she said, why do you think you have carpal tunnel?

I said because it hurts here.

She said, no, dear, you've just got rheumatoid arthritis.

I said, oh, good, that's even worse.

(Laughter.)

So, you know, we're all guilty of that sort of thing.

Yes, Holly wants to make some more comments.

HOLLY KING
M-PLAN

I just wanted to add to what Dr. Emkes said. I mean that is exactly -- we have our

pharmacy, our PNT Committees that decide this, but I understand too that we're an insurance plan. We're competing, for instance, in the State group with the self-insured plan, so we have to be as constantly vigilant as any other administrator or employer.

You know, if they're looking in -- truly there are hundreds of changes everyday in these drugs, new ones come out, and patents go off, and you find out you can delete some and save money that way, so, you know, we have outbound call programs, we try and get to the physician or the patient first and get them on board with what will be more cost effective, but I guess the bottom line is, that, yes, it has to be medically effective, but we have to be very cognizant of the cost effectiveness of it.

So if it's going to be cheaper for us to take you off your drug and move you to something where you can split pills, you know, we're going to try and have that happen, but, you know, we try to do it in a friendly way.

MS. MALOOLEY: I didn't ask that just for

State personnel. I'm asking it because other people --

MS. KING: Understood.

MS. MALOOLEY: -- complain about calling the doctor.

MS. KING: Understood. And I'm just using you because you have both types of insurance plans, and I'm just saying that, bottom line, we have to be as cost-effective as any self-insured plan.

HEARING OFFICER CUTTER: Thanks, Holly.

Do we want to talk a little bit about what's happened in some other states in terms of this issue, kind of bounce that around.

MR. SEITZ: Yes.

HEARING OFFICER CUTTER: Yes, Dan.

DANIEL B. SEITZ
BOSE McKINNEY & EVANS

I'm Dan Seitz. I'm an attorney with Bose McKinney & Evans, and I'm the managing principal of Bose Public Affairs Group, which represents a number of entities including the Indiana

Association of Health Plans, which is primarily an HMO association that also has insurer members. I also represent individually Aetna and Humana.

I had hoped not to have to be at this rostrum, but I think there needs to be a little bit of clarification provided here to kind of bring this all back around to focus on what is doable and, trust me, as an increasingly older and more frequent user of the system, I have a lot of interest in what happens. So although I represent the payers, I've had a lot of experience in the last several years with providers. So I do appreciate the difficulties of the practice and the difficulties of providing quality care.

Let me start by saying part of the problem here, and the reason that we're in this room, is because I think today is a perfect example, this discussion has been all over the block. There has been no focus. Allegedly, we're talking about preauthorization but we keep going off into collateral areas. I think to find solutions we can only do what we can do. Unfortunately, the anecdotal information that we have received from

you, as providers, doesn't necessarily suggest a solution that is workable or that payers could be in a position to support.

What we're trying to find is some middle ground here that we could support. I had talked to the Department earlier this week indicating that I think there was great sympathy, for example, for the issue of retroactive denial after precertification, and we felt that there were some examples in other jurisdictions that would possibly lend themselves to the development of a Department bulletin that would impact insurers.

However, the anecdotal information here doesn't necessarily identify whether in fact it is an insurer, and let me define for you what an insurer is because I don't think you really understand that. An insurer, from our perspective, is an entity that assumes risk and pays claims based on that risk that they have assumed.

The 40 percent of the market, or the 60 percent of the market on the opposite side that Chief Deputy Commissioner Cutter mentioned, only

40 percent of the market today is insured. So all we can talk about in this room is what insurers do. We can't talk about what the other 60 percent of the market does, i.e., self-funded plans; companies such as Aetna, Humana, Signa, M-Plan, who may be providing administrative services only, those are ERISA services and they are exempt.

So when you give us this anecdotal information, I can't do a thing with my clients without understanding was this actually an insurer speaking or was this a company that also happened to be an insurance company that is representing a self-funded employer. And until you understand that distinction, we're not going to get very far, because if it is the insurer that is causing the problem, then we're in a position to do something, and the Department of Insurance and the Legislature can do something to that, and that's what we're really here in the room to talk about and hopefully find solutions.

But there again too we are straying all over the place with all kinds of problems, and it's understandable if I were a provider and had a

forum, I would be talking about everything under the sun too, because, again, I do appreciate how frustrating it is to try to practice and provide quality care today.

Let me just touch on a couple of things. The suggestion that there be -- and I'm wearing my attorney's hat now -- the recommendation that there be a central registry. I believe firmly that would be an anti-trust violation, and I don't believe it's feasible. The trade secrets of insurers relate to how we pay claims, the criterium in which we use to make those decisions, because we're in competition with one another. By law we have to do that. So if we put all that data you want up, so that anybody can go to it and see it, and anybody, includes any physician, employee of a physician, then we are in violation of the anti-trust laws both Federal and State.

MR. YODER: What kind of a central registry are you talking about that was suggested here? I'm not sure I know one was.

MR. SEITZ: You asked for a -- I'm sorry -- a central clearing house. I'm writing down

what you said at the very outset.

MR. YODER: I guess my suggestion was, is there a central way that the State can say, look, we have common medical practices, we have AMA guidelines, we have scientific guidelines, is there a -- it's not how you go about -- preauthorization, prior approving, we're not talking about that --

MR. SEITZ: I understand that.

MR. YODER: What we're talking about, is there a central -- is there a way to simplify the whole process because as it is now, even within one insurer, it is not uniform. There are different programs, different policies, even within one.

MR. SEITZ: Are you talking about the insurer as an insurer, or the insurer as an administrator of a plan?

HEARING OFFICER CUTTER: Probably both.

MR. YODER: Yeah, I think both. And here's part of the problem though, as providers we don't know if the insurer is the insurer or the insurer is a payer, that is not clear.

MR. SEITZ: That may be something that we can deal with.

MR. YODER: And that's part of the problem, frankly, with the insurance industry.

MR. SEITZ: I absolutely agree, and not having sat in your shoes as having to deal with this on a daily basis, I can appreciate the difficulty of knowing who you're really talking to.

MR. YODER: So from our perspective as a provider, it's all the same, because we're dealing with you as the insurance company, the payer. How you divide your business beyond that, is your business.

MR. SEITZ: Well, actually it's your business too because, again, let me state that if all the insurer is doing is representing an employer, it is the employer that determines what the plan parameters is going to be and clearly there are going to be differentials between plans within an administrative services arena.

MR. YODER: However, our contract is with you, as the insurer, not with the employer.

MR. SEITZ: Well, I'm not going to get into that right now. I think that's a whole different discussion as to who your contract is with and what those contracts actually say. But I think that's another issue that's being discussed actually in another forum and we will be probably dealing with that too.

Let me just make a couple of other comments. But I do believe that there are anti-trust issues in some of the things that have been suggested here or at least the implication, as I heard them, would have required disclosure of information that is owned and developed and maintained by each company, and those are proprietary in nature.

MR. YODER: It doesn't have to go to that level.

MR. SEITZ: Okay. Well, I'm not sure how we get to where you need to be and not get to that level, because again 60 percent of the market is going to drive your problems and you're not going to touch them and you can't force anybody to do what you're asking.

MR. YODER: But that does not mean that we ignore the other 40 percent.

MR. SEITZ: I'm not saying that.

What I'm trying to say is, we somehow have to find a way to focus on that 40 percent and figure out what is doable there. That's what I was suggesting, that we think that there may be some things that can be done to assist at least in some of the issues that have been raised. Okay.

I know this issue of reductions has come up a number of occasions and I haven't seen numbers and I don't now that numbers actually exist except internally among those that need to be able to address those but part of my frustration representing the clients that I do, is being in a forum like this and not having the people here that can answer directly or respond directly, and there again my opening comment was, we are so broad in these discussions that it's physically impossible for us to bring all the people from each insurance company into this room so that we've got the right person to answer the question that may be raised, because formulary

decisions may fall in one area and there are certain people that are allegedly expert in that; medical directors may be involved in that, they are involved -- different medical director may have different functions with respect to others. We have claims people. We have underwriting people. We have all these people. So to bring a person here today that can answer all those questions is very difficult and we tried hard to try to get that done, and I think we may have done a better job last time than we were able to do this time, but I just want you to understand that that was not for the lack of interest or the lack of sensitivity to the problem.

I was struck a little bit by the issue of the gatekeeper. The insurance industry felt very strongly that this did hold a promise because we would have providers making the decision, but, of course, it was the provider community that went to war with the insurance industry in the Legislature in this State and very successfully killed the concept of gatekeeper, so you need to talk to your own colleagues about that.

I'll talk to you, if you want to talk about it. I'd be happy to talk to you later. I'm not going to get into that right now, that was a very brutal issue for a couple of years.

I just want to touch too on the waiver. As an attorney, and I'm not going to pretend to speak for providers' attorneys, but I'd be a little worried about a waiver list. Who is going to make that decision? You're going to have the same problem we've got now or you think you have now because each individual company is going to make that determination.

I know that there have been efforts and I don't think they've been wholly successful on the part of the State Medical Association to deal with some of these issues of how do you measure quality. I believe the Hospital Association has done a little bit, has had a little more success with that. But one of the things that we're sensitive to is that from your perspective, you start getting into questions of quality, start getting into questions, the very issues that Dr. Patterson raised, you know, I'm the one on the

scene, who is to tell me after the fact that what I did at that point in time knowing what I did, was wrong. Yet, that is what's implied or may be implied by having those kinds of systems.

So, I mean, I think the insurance industry would strongly embrace a very strong system which in some fashion indicated who the A-list providers were and who the outliers were, so that we could avoid those people.

So we're not necessarily opposed to that but I think you've got -- there again, you're opening up some issues that I don't think very many people are going to want to deal with particularly in front of the Legislature.

Am I right, Zach?

ZACH: Maybe.

MR. SEITZ: Oh, really, well, we'd be happy to work with you on that legislation.

That's really all I wanted to say. I just wanted to try to add a little perspective and not be up here lobbying you, but more to just say, look, this is a huge issue.

We've tried to have the right people here to

deal with preauthorization and that was what we were focused on.

We think that there may be some things that we can do in that regard. We have offered to work with the Department in that regard, that would be in the form of some bulletin that would essentially effect insurance companies in their insurance plans, and it would be similar to something that has been adopted in Idaho, and it basically says that the only reason you can have retroactive declinations are limited to some very specific things, such as what Holly mentioned, non eligibility, because at the time you called, you know, it's the employer that determines eligibility, not us, and the information we got on the day you called may indicate the individual is covered and we find out that in fact that person has been terminated but the paperwork hasn't caught up.

There may be non-payment of premium issues. There are some other, we think, reasonable exceptions, but we're more than happy to explore those at the appropriate time.

Thank you.

HEARING OFFICER CUTTER: Thank you, Dan.

I think he makes an important point about the ability to think in two worlds, the self-funded world and the insured world, because the providers unfortunately are going to be impacted in both of those situations.

Let me read you some of the different states, I'll go back to Idaho since Dan raised that in his comment. When prior approval of covered services has been granted, the managed care organization may not rescind the approval after the covered service has been provided other than in case of fraud, misrepresentation, non-payment of premium, exhaustion of benefits, or if the member is not enrolled at the time the service is provided.

So that gives the provider a pretty wide scope, I would say, other than any of these minor circumstances. I tried to thumb through these as he was talking. It looks as though most of the other states that have some sort of either statutory or regulatory reference to it, are

similarly worded. Some of them are much more detailed than that but that's the general overriding concept.

Just a show of hands for the providers and for the carriers that are in the room, is that a reasonable place to start?

(A show of hands.)

HEARING OFFICER CUTTER: Good.

MS. KORTY: Do you want to say a number of hands for the record?

HEARING OFFICER CUTTER: Almost half, did you think, of the folks that are in those categories probably -- no. I would say most of the folks in those categories raised their hand.

The other thing I was thinking as he was talking about the self-funded, which he used that other term, administrative services only, that's the same thing as the self-funded, in other words like the State plan, Anthem is our administrator, but as Dan said the State helps design what's going to be covered, what's going to be paid and what's not going to be covered and paid, and therefore in those kind of self-funded groups

you're going to get a huge variation from one employer to the other.

Would it be helpful as a provider since ID cards are something that we also can address, that if you had some indication of that on an ID card would that make any difference? I mean I don't know, I'm just throwing things out here.

Dr. Patterson.

DR. PATTERSON: Well, it would make a difference in terms of how we explain to the patient. I mean it's one thing if you say to the patient, it is your insurance company that is doing this; it's another thing if you say it is your employer. They would look at that much differently.

HEARING OFFICER CUTTER: Yes, that's absolutely true.

DR. PATTERSON: And we frequently, as providers, tell the patient you need to try to influence the HR person of your employer.

HEARING OFFICER CUTTER: Right.

DR. PATTERSON: And that may or may not be appropriate.

HEARING OFFICER CUTTER: So maybe that's something we could incorporate into part of this recommendation that we make to the council since that would help you cope with some of the animosity that probably arises when the patient finds out that that's the circumstance.

If you knew it was a self-funded, if there was some indication on the ID card it was a self-funded group instead of a fully-insured group, I mean that's a beginning anyway. Okay. We will make note of that.

DR. EMKES: So would you be putting OWA on the card?

(Laughter.)

HEARING OFFICER CUTTER: Yes, Bernie, we'll use your designation, this is OWA, look out. You're on your own.

Any other comments to that?

Yes, Dr. Patterson.

DR. PATTERSON: I think Mr. Seitz' comments were good for providers to hear.

But I would simply remind you that at the last meeting I made a very concrete proposal that

you alluded to, which was, we take the outliers, which are a small number of people, and we confront them and say, look, is there something here we're missing as an insurance company? Because we want to separate out -- we all want to separate out the people who just got a CT scan, we've got hemorrhaging of the nail, none of us would agree with that type of treatment or that type of medicine, versus the person who had the different patient population or some other extenuating circumstances that might explain, quote, why they're over-utilizing a certain procedure. I'm talking about precertification here.

That seems to me to be a much better process to look at selected people that are over-utilizing based on claims versus making an onerous system on every provider which is what we currently do. So I'd like to get some response from the insurance side as to why we can't do that because as a simple-minded straightforward physician, that seems a lot better than what we have as our current system.

HEARING OFFICER CUTTER: Well, I'm going to pick on Aetna if they're still with us.

Ladies, did you hear Dr Patterson's comment?

CHORUS: Yes.

MS. STEPHAN: Thank you, this is Bonnie Stephan, and I did.

Doctor, when we get questions or when questions have been directed to me, I would suggest for most physicians, someone that you might think is an over-utilizer based on your experience and your knowledge, when we talk to him, they believe their population is unique and he would be doing what he felt was appropriate care.

So it's difficult, you know, it's very very difficult to identify this 20 percent of the outliers and these 80 percent that everything they recommend or do is appropriate and the proper utilization of resources. We're open to suggestions.

MS. MALOOLEY: This is Jerry Malooley. As a carrier you have the authority to do on-site

claim audits and chart audits, and I know that's going on across the nation right now while we're working on this quality initiative, one of the four cornerstones from CMS. So couldn't you utilize your auditing to discern the type of patient that this physician is particularly seeing and treating? You could also use claims data.

MS. STEPHAN: I am not sure that if we think they're an over utilizer that we can go in and audit that physician.

MS. MALOOLEY: Yes, by contract, I believe you have the authority to do that.

MS. STEPHAN: Yes. I don't know that that would be practical in this day and age to go in and do an audit of every physician.

MS. SULLIVAN: A standard of practice to audit who is using what where? I don't know where that flows down.

HEARING OFFICER CUTTER: Well, I believe the question was in regard to the outliers.

MS. SULLIVAN: And it's identifying the outliers.

MS. KING: But who is going to be the

ultimate judge, then?

VOICE: And what do you do with them if you find out they are outliers? The money is already spent.

HEARING OFFICER CUTTER: Education.

I've been through this. For ten years I've been wrestling with this, yes.

DR. PATTERSON: You're judging us now, it's prospectively instead of retrospectively. We're not changing the judgment process. We're just changing whether it's prospective or retrospective in how it's done. The criteria is still the same. I don't understand your argument.

This is Dr. Patterson. It's the same criteria.

MS. STEPHAN: We're having a very very difficult time hearing all the comments.

DR. PATTERSON: Should I stand up?

HEARING OFFICER CUTTER: Please.

Did you hear what Dr. Patterson just said? Aetna, did you get to hear what Dr. Patterson just said?

MS. STEPHAN: No, we didn't hear the last

thing at all.

HEARING OFFICER CUTTER: We'll repeat that. We're sorry.

DR. PATTERSON: This is Dr. Patterson.

Let me see if I can understand what you're saying and if I can articulate what I'm saying because I think we're saying the same thing.

Let's take an example, let's say we have someone who comes in with low back pain. They hurt their back a few days ago and they have low back pain. They have no neurologic symptoms -- you've done an examination, you see no neurologic symptoms and therefore based on the current criteria you would say they don't need a CT scan of their back, of their spine.

Now whether you apply that criteria before the CT or after, it's the same criteria.

Now the only argument is what was just made is, well, if we give the CT, then we've already paid for it, and I understand that. But that's not in that many cases, because remember we've already determined from the last meeting we had here that it's the minority of procedures,

it's the minority of precertifications that are denied, so we're talking about a small number here. And we're likely talking about people who are doing this over and over again. We're likely talking about people who got the CT scan and now everyone gets a CT who comes through the office, and we all agree in this room that's not appropriate. Those people are easy to detect in your claims data with the same criteria you would detect in a precertification, it's just after the fact, not before. But the bureaucracy now becomes less burdensome by a huge factor on physicians, and as our panel has said you educate those physicians. So it's not a matter of arguing over, well, who is doing what or can we agree on this, you use the same criteria.

Does that makes sense?

MS. STEPHAN: Yes, it does. Thank you, and I was able to hear it. Thank you.

I think it's an interesting point and it's certainly something that we can take back to our medical quality people and see if they're interested and suggest that for those physicians

or other healthcare providers who are -- not the outliers -- who are using the resources, you know, in a reasonable way that there be some type of waiver, if you want to call it a waiver for the want of a better word, where they're not required to follow certain preauthorization requirement and it's for those physicians that appear to be over-utilizing resources to have somebody investigate that and be able to separate and put them on a pre-cert requirement.

You know, administratively, I can see all kinds of problems but it's definitely one of the reasons we like, if we can, to get physicians' perspective and see what's happening in your day-to-day practice and we'll certainly bring this back to our internal staff and our policy board to look at these issues.

MS. SULLIVAN: And the other thing I'm going to add is that the logic that led to the reduction of pre-cert requirements, so where that comes into play specifically to kind of pre-cert we can certainly step back and take a look at it and if there are particular instances where a

particular pre-cert is problematic we can give those specifics to the medical group as well.

HEARING OFFICER CUTTER: Thank you, Aetna, Thank you, Dr. Patterson. I think that was a very important exchange, actually. So we're going to focus on that potential process where providers who are not from a claims auditing perspective of using or over using particular category of services, which would have a pass or a waiver and then the insurer or the HMO, if that would happen on the HMO side for those providers who fall into that either abusive or over-using category could certainly initiate or create some gatekeeper kind of thing they have to go through in order to have the radiology services or whatever the category is that that provider is over-using, makes very good sense.

The second point is we will start with some similar considerations that we've just read you out of the Idaho code about not allowing a rescission of an approval of a pre-authorized service or treatment for other reasons than the ones that I read to you from the report.

Everybody seemed to be pretty much in agreement with that.

The third piece would be the identification cards. If there's some way -- so the physician could address -- if there's some way for the insurers to indicate when it is a self-funded plan so that the providers can be able to make that explanation to the patient so that there's more understanding, I guess I should say on the patient's part that this is the employer decision, not an insurer decision.

Honestly, I think ultimately, that will have a huge impact in terms of the patient's perspective or perception about the insurance in general and that's one of the things we've got to overcome. We have to make people understand this world as complicated as it is and how it works and why it works the way it does. I think that's a huge step in the right direction.

Let's do this, let's touch on those other two or three things -- if I can find the agenda -- that the Senate Bill enumerated so that if there are folks in the room that have concerns about

those issues or suggestions or recommendations or want to explore that topic, then we'll start that conversation today, because our next meeting, which is our last meeting, will be our wrap-up.

We'll bring up summarizations of these issues that we've just gone through and try to come to some reasonable recommendation for the Legislative Council.

All right. We didn't talk about the explanation of benefits form. Let me see by a show of hands folks in the room that think that's a conversation they want to have?

(Two people raised their hands.)

HEARING OFFICER CUTTER: We have a couple of folks that were concerned about that. Let me ask this question, specifically about the EOB, can you tell us, can you enumerate a couple of things that you think --

(Affirmative response.)

HEARING OFFICER CUTTER: Yes, please come up.

LINDA GATES-STRILEY
CARE GROUP

I'm Linda Gates-Striley with the Care Group. On the pre-cert, preauthorization I guess one of the things we really didn't talk about, and I'd just kind of add to the list, it sure would be nice if the people we spoke with understood English well. That's an increasing challenge as this has been an outsourced function with phone lines that are down and it's very hard to explain a complicated cardiac procedure to someone who has just learned English; that's kind of difficult.

Another issue when it comes to the EOB or remit, I think if we could just agree to a standardized format of some sort, you know, something as simple as they're not in landscape. You know a lot of us are going to scanning systems and different ways, you know, shading -- if you could just eliminate shading, if you could get it going in the same direction, some pretty simple stuff, I mean it would be wonderful if we could get to the point where we sort of agreed on remit/remarks, how you would define those and

maybe come up with some consistency there too.

I think we're all moving to be as efficient as possible, electronic as possible, as automated as possible, so as many areas as we can get -- you need the same thing with insurance cards. I think everybody copies or scans an insurance card and if you have your nice beautiful shiny circle on there, well, that copies black and it's right over the number, so now we're having difficulty with that. So even on an insurance card, if they could just be black and white, or if you're going to put designs or highlights just don't cover required information with them.

So I think there are some other things that we could maybe do, if you could have the deductible amount on the card or the co-pay on the card. I think there's a lot of things with both cards and EOBs. There's some payers that process the EOBs and then we have to do the math, factor the write-off amount, you know, that seems pretty basic; here's the charge, here's the allowed and then another column which makes it very easy for someone who is processing claims, but when that's

not even there -- so I think there are some things we can maybe talk about and have some consistency that would be fairly easy to implement.

HEARING OFFICER CUTTER: Thank you.

I think those are all good points for us to throw into the mix as well.

The next one is timeliness, filing of claims by providers to insurers and HMOs. Now, we're going to switch tables on you guys. Now, the industry gets to whine about the providers not timely submitting claims. Do we have any of the folks from the industry that want to speak to that issue? Is that something that you see as a fairly prominent problem? Is it just an occasional infrequent thing?

(No response.)

HEARING OFFICER CUTTER: Nobody knows.

VOICE: We didn't raise it.

HEARING OFFICER CUTTER: I don't know who did raise it.

All right. I tell you what we're going to do --

MR. YODER: I'll speak to that. May I?

HEARING OFFICER CUTTER: Yes, absolutely.

MICHAEL YODER, CEO
SOUTHSIDE FAMILY MEDICAL GROUP

Michael Yoder, Southside Family Medical Group.

Again, I would like to reiterate what was said about EOBs, it would be nice if we had everything in identical format. I don't think that compromises any laws or any type of collusion. I may be wrong, I'm not a lawyer.

On the insurance cards -- before I get to timely filing. On the insurance cards, you know, we are starting to scan cards and if we could have an identical layout, again it would just ease the flow of information, it would cut down on filing errors. You know, we can designate this part of the card gets scanned into the account number. We can designate this part of the card where the co-pay gets scanned into the co-pay field, so we get accurate information all the time, every time, put into the computer system. It seems pretty

basic.

On the issue of timely filing. This is actually an issue that I raised. Actually, the doctors in our group raised this last year with ISMA about the issue of timely filing in Indiana, and it is left wide open. You'll find that insurance companies have different policies. For example, with Signa, in-network providers are actually penalized over out-of-network providers. In-network providers per their own web site have six months to file a claim. Out-of-network providers have 365 days to file a claim. TriCare has 60 days to file a claim. Different insurance companies have different guidelines on timely filing.

You know we have issues where the patient may not give us the right information up front, and by the time we are able to track down that patient, get the information from the patient, and if we have a 45-day timely filing limit, we're past that filing limit.

The patient says, can you please file it anyway, give it a try, see if they'll pay it. If

we file it, then we get the denial back, we are technically not supposed to turn around and bill the patient because we filed on their behalf.

Now, our argument with the patient on that point is, look, you did not give us the timely filing data. You know, we missed a deadline because you did not provide us with that information.

Senate Bill -- last year Senate Bill 147, which became law this past year, gives insurance companies a two-year limit to go back and request a refund from providers for errors that were made by the insurance company. What I would like to see is a similar amount of time for providers to discover our own errors, whether it's our mistake, whether it's because the patient did not provide us information, but give us time to find our mistakes, correct those mistakes, and refile those claims with the insurance company.

You know, it's not in our interest to hold those claims, and I understand that insurance companies need to close their books. At a certain point they need to be able to say, okay, look, our

books are closed, the losses are taken, you know we've paid out all we're going to pay for that period of time. That's a part of business you have to be able to close your books. At the same time we need that time, we need to be able to say, hey, look, I'm sorry, we missed it. Sometimes when you don't see a patient but once a year, you may not catch it until that patient comes back in the next year for their physical. So, again, I would like to see a two year timely filing limit uniform across the board for Indiana.

MS. STEPHAN: Hi, this is Bonnie Stephan, may I ask a point of clarification?

HEARING OFFICER CUTTER: Yes, ma'am.

MS. STEPHAN: Thank you.

We have several states that have a 24-month or two-year period before -- determination period before a claim is final; Ohio does, Kentucky does, I think, anyway, there's several of them. Anyway, when you're talking about a timely filing method, hopefully that is talking about finding mistakes and going back, and not the initial filing, because plans change. If

you wait two years to submit the claim, especially for a self-funded plan or even some insured plans, they may be gone with other carriers. Especially the self-funded, it could be outside of any monies that would be available to pay. So if you're going to go that route, I would suggest you have one for at least the initial submission and then for the two-year put that to correct anything, like the example you used.

That's all.

MR. YODER: Thank you. That is a good point that policies can change, plans can change, payers can -- companies do switch payers and I acknowledge that and you're right about that.

I guess my initial concept is for the initial filing, not simply an error correction.

You know, if we can have clarification on the issue, look, the patient gives us a United Health Care card and in fact they're an Aetna customer, we file with United Health Care, you know, they come back in next year, you know we get the rejection, we notify the patient that, you know, the plan didn't cover, they need to pay us.

Can we turn around and file with Aetna beyond your normal timely filing limit. You know, if we can get clarification and get something uniform across the board in that regard, we would appreciate that because as of now it seems to be hit or miss.

We will always turn around and try to refile with the correct insurance company but there does not seem to be any rhyme or reason as to whether or not it is accepted the second time around or it is rejected the second time around because of untimely filing.

MS. STEPHAN: Okay. Thank you. Point taken, and it's going to have to be something that we can administer on a broad level, and I don't know if you're speaking to Aetna or other carriers?

MR. YODER: Insurance in general.

MS. STEPHAN: Okay.

MARCIE HART, OPERATIONS MANAGER
ARNETT HEALTH PLANS, UHC

Hi, I'm Marcie Hart, from Arnett Health Plans, UHC, and I have a couple of things, you

have been jumping ahead, and I haven't had the opportunity to come up.

I think you raise a really good point about the cards and EOBs. What I think are your barriers that are going to come into play, that not all of your carriers are domiciled in the same state. They also have centralized printing areas and data bases that feed that information into and each state is going to have their own regulations. So the costs are going to go back to the employer.

I think what a good rule would be for -- what was said, print it on black and white. Let's see what it looks like. I think that's one of the first thing that somebody should do, you know, and I think maybe the employer and the provider need to get together and maybe discuss this, maybe not in this forum, because, again, we're just talking about managed care plans, but looking beyond that.

HEARING OFFICER CUTTER: Thank you, Marcie.

I can certainly speak to that issue. Several years ago, before I was at the Department, one of the things that agents chafe about is that

every insurance company has a different application or questionnaire form that they require an employee to complete in order to even give an approximate pricing quote up front before that group agrees to accept it or any enrollment forms are completed, and every carrier has a different one.

So if you're going to try to help your employer pick a competitive product, then the only way you can do that is to have employees fill out six different forms for six different carriers and send them off to those carriers to get your pricing back.

We try, because of that situation, to go to some of the carriers that write more group business in the State, and we said, is there a way for us just to have a standardized health questionnaire that will give you the basic information that you need? It's not real detailed, especially in the small group market because they have to take them anyway because of the guarantee issue. What we were told was it wasn't that they didn't want to cooperate or they

were that tied to their own form, the problem was their internal computer system. Those forms are set up in certain order, those fields are in certain places on that page and those people that do the data entry are used to the way that it is structured and it matches their internal operation system.

In addition to the points Marcie made, I would expect that would be part of the problem too in terms of standardization.

Unfortunately, it's just one of the facts of life on a daily basis. Yeah, it's very frustrating dealing with that situation, but we will certainly consider that and see if there are any not-to-onerous opportunities to try to accomplish some of those things.

I think the last issue we had concerned out of network providers being given reimbursement rate information after precertification of a service has occurred for the insurer, the HMO to notify them once that -- what that reimbursement rate is going to be. I need to see by a show of hands how many folks in the audience have a

concern about that or would like to discuss that any further.

(No response.)

HEARING OFFICER CUTTER: Okay. We won't talk about it.

DR. PATTERSON: Out-of-network providers see a patient and instead of getting paid they send the check to the patient and we have to run the patient down.

HEARING OFFICER CUTTER: Let me tell you why that happens because an insurance contract in the State of Indiana is predicated on a reimbursement process, which says the insurance contract -- if I'm in a group policy, I'm a certificate holder, and the group policy says that I'm supposed to go out, get treatment. I'm supposed to pay and then the master policy or the insurance policy is supposed to reimburse me. They are all worded that way. So as a legal contract they are a reimbursement arrangement, not a direct payment to a provider.

What the providers have done over the years, and I can't say I blame them, is they went

to the insurers and said you guys, you know, you're sending all this money to the patients and we never get it or we don't get the portion we're supposed to get.

So the insurers agreed to an assignment of benefits, which is something that you guys have every patient sign when they come in, you probably do it more than once, which says, an insurance company, I, the patient, have told the insurance company they have my permission to pay you the money instead of sending it to me.

So an out-of-network provider is simply functioning under the process as the legal contract stipulates and because they're an out-of-network provider, they don't have an opportunity to do an assignment of benefits because the insurance company wouldn't recognize it anyway since they're not part of their contracted network arrangement.

I mean that doesn't help the fact that you don't get the money. I just wanted you to understand why that process takes place the way it does. I know there have been some efforts by some

organization to try to force insurance companies and HMOs to accept assignment of -- well, an HMO wouldn't have to do that -- but to accept an assignment of benefits for out-of-network providers. I know that's a topic that's come up a couple of times in the last couple of years. I don't know that it ever got anywhere but I know it's been raised.

Anything else that anybody has? Are you dying, you guys? It's miserable in here. I apologize. We were so excited because we thought we had the big room today but the temperature has just been horrible even with the door open, so I apologize.

I guess that's it unless anyone has any other comments they want to make.

MS. MILLER: I'd like to say something.

HEARING OFFICER CUTTER: Yes.

MS. KORTY: While she's walking up, I just have one point of clarification, your agenda has Linda Merkl of Associated Reporting, and that's actually Accelerated Reporting. It's very confusing because Associated Reporting was here

last time, but if you're trying to reach Linda, call Accelerated.

LORI MILLER

My name is Lori Miller. I'm here today to represent the public. I don't think anybody was here last month and I don't think anybody else is here this month.

Basically, I came here to learn and to listen and to hopefully find out if what this study was doing was going to coincide with something I'd like to see happen.

I listened to the providers talk about their problems with precertification and the insurance companies, and I guess we're all patients here, so I guess you know what a precertification means to a patient, which is pretty much absolutely nothing. I mean it's certainly no guarantee of payment.

All these forms -- the preauthorization, the precertification, EOB, the ID cards, you know, they're basically all from where I stand -- I mean

you're all the experts, but for me, they're all contracts that are probably more than likely -- I'm just making an assumption -- written by an attorney and they're probably crafted by an attorney in the best interest of the insurance companies, and that's fair enough, you know, they need to protect their interest and protect against fraud and limit liability and reduce the cost of insurance.

But what I want to know is where are the protections for me and for you and for the provider? That's what I need. Right now I'm in the middle of my own insurance nightmare and it all relates to forms and administration, and I need help. What I need is, I need a law that will provide some type of protection, not to take anything away from the insurance company, but something that will help protect the other thousands of people in Indiana right now who purchase insurance that could find their self in my exact situation, and that's a place where you just don't want to be right now, trust me.

I really truly believe that this

standardization of forms, I know it might cost a lot of money to do, maybe there's some reason you can't, but I truly truly believe that would be something that would help providers, it certainly would make things simpler for small businesses and for purchasers of insurance.

I'm glad that you're all here.

Thank you.

HEARING OFFICER CUTTER: Thanks, Lori.

Anybody else? Any final comments before we dismiss and everybody runs out of here to the air conditioning?

(No response.)

Thank you all for coming. We appreciate your time.

(Hearing ended 3:00 p.m., August 22, 2007.)

STATE OF INDIANA)
) SS:
COUNTY OF HAMILTON)

I, Linda R. Merkl, a Shorthand Reporter and Notary Public, in and for the County of Hamilton, State of Indiana, do hereby certify that the foregoing hearing was taken on behalf of the Department of Insurance, in the matter of SB 372, beginning at 1:00 p.m. on the 22nd day of August, 2007;

That said hearing was taken down in stenograph notes and afterwards reduced to typewriting under my direction; and that the typewritten transcript is a true record, to the best of my knowledge and belief;

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 4th day of September, 2007.

Linda R. Merkl

Linda R. Merkl
Notary Public
Residing in Hamilton County

My Commission Expires:
January 27, 2009

Topics for IDOI Study Committee

8/22/2007

1. **Radiology Pre-cert processes**

2. **Pharmacy Pre-cert processes**

There is no question the costs of health care are rising and must be addressed. Society cannot afford all the rapid advances in diagnostic testing, pharmaceutical products and end of life care that the 'sick care' system is today providing.

However, there are processes being put in place today that make little to no sense, place patients at risk, and promote inferior care under the guise of health cost reductions.

I am a physician. Physicians are trained to diagnose and treat patients. While there is a great deal of science in medicine, the term *art of medicine* is still most frequently used to describe a patient - doctor interaction. Decisions about health care are made between a doctor and a patient, taking into account past history, psycho-social situation and other intangible factors.

Part of the problem of rising health care costs has been the rather complete disconnect between costs of health care and the end user of health care services. I do not really care what a service costs, as long as someone else is paying for it. And as an added feature, the negative side of numerous radiation exposures and the risks of surgical procedures are often underplayed. These facts have led to over-utilization of health care services, and in my mind are the reasons for the current push to *consumer driven health care*.

But currently the reaction to high health care costs is to place as many barriers as possible to influence patient – doctor decision-making, and all too often that falls on the doctor – not the patient.

Radiology and medication pre-certification processes have become so cumbersome that, as a health care system, we have heard an outcry from our doctors and their medical office staffs. The extra time on the phone to get the

EXHIBIT

wm 1 8/22/07

proper "mother may I" is overwhelming to many offices. At least two insurance plans are now directing care to lower priced providers. One can only hope that quality is evaluated prior to this transition of care. That concept in itself is somewhat scary for patients who assume all quality is the same. Once insurance plans begin to direct the care, they are indeed deeply involved in the medical decision making process, and that may be a breech of the Indiana practice act regarding the corporate practice of medicine.

But a second piece of this story is even more bothersome. Not having processes in place to rapidly approve necessary services, and quoting policy as a reason for delays is placing Indiana patients at risk for bad outcomes. And for what? One reads about increasing insurance company profits and ever larger CEO bonuses? How again does that improve patient care? Patients with serious or even potentially serious conditions need tests to confirm or refute those devastating illnesses. Delay in approval for those tests is placing Indiana citizens at risk for worsening conditions, increased pain and suffering, delay in definitive diagnosis and even death.

Plans point to the radiology pre-cert vendor. The vendor says they are only doing what the contract services agreement calls for. What is going on? Who will need to have a bad outcome before some reason is brought back into the system? And that is just the radiology issue.

Now to tackle pharmacy pre-cert requirements.

We fully understand rapidly increasing costs in pharmacy. New drugs, with patent protection, are more expensive. And "me too" new drugs do not add a lot, except to protect high profits. Generics are cheaper and often effective, but not for all. We all need and want that new drug that works for us when we get sick.

There might even be a place for pre-certification of new or narrowly used pharmaceuticals when prescribed by physicians not accustomed to their use. However, highly trained specialized physicians need to have access to the best - the newest – and yes, the more expensive medications. Older medications work in many patients, but by the time a patient gets referred to a sub-specialist, most of those medications have been tried and have failed, or are incompletely controlling the problem. Perhaps if a correct drug were easier to get, even the referrals would decrease.

And there is also the issue of compliance. Will a teenager take even one dose a day, and how low will compliance become if we ask him to take two doses of a less expensive medication. They say the most expensive medication is the one that does not get taken. How does that balance with newer, safer, once a day medications compared to older less expensive medication not taken?

I am personally a conservative by nature. I am reluctant to ask for any government intrusion into processes impacting physician and patients. Yet the situation is rapidly reaching a boiling point. When artificial processes interfere with good patient care, I have to speak out.

Thank you for the time and for listening.

Bernard Emkes MD.

The Dark Side of Health Insurance Plans

8/22/2007

Citizens of Indiana beware! There is an insidious process occurring through many of your insurance plans that is supposed to reduce your costs for health care. In certain instances, these processes, designed to save money, may actually be putting your health at risk. While the process is purported to save you money, insurance plans also increase their own profits by building hurdles to appropriate and necessary care. This is very concerning to physicians trying to provide Indiana citizens' proper and timely health care. However, CEO's of these large companies must need your insurance dollars more than doctors, hospitals and other health care providers – most of you have seen the reported bonuses paid to some of these CEO's.

The issue is this. Many large insurance plans are requiring a "mother may I" pre-certification process for radiology services. This process is required for all services except those ordered in the Emergency Room. While many would agree that elective tests can be run through such a process to substantiate the need for the test, there are, or at least should be, exceptions.

When your physician feels a test is needed immediately, at least one contracted radiology pre-certification plan is stating they have 4-24 hours to approve that test needed STAT (now). Most physicians would feel this is a blatant obstacle, totally inappropriate and a threat to the good care your doctor is attempting to provide. Your safety as a patient could be threatened by this requirement. The plan will not pay a provider for the test if proper pre-certification is not obtained. That may also place you as a patient at risk for paying the full bill should you and your doctor decide to go ahead and get the test without the pre-cert.

So if you show up at your doctor's office with a possible blood clot in your leg, abdominal pain of unknown cause, or a head injury (something less than being completely unconscious), you may not be able to get the proper test you need immediately under this new process. Delaying diagnostic services in cases such as these places your health at risk, and also increases risk for further damage or harm – and even death.

One plan has had the audacity to suggest "If they need the tests that badly send them to the Emergency Room". That is so counter-intuitive as to be ridiculous. Send a patient to the highest priced services available so as not to disrupt an insurance company pre-certification process! How absurd does that sound? A primary care physician serves patients. They are well trained to test, diagnose and treat most medical conditions. Let them do their jobs. In an effort to reduce costs, this poorly implemented pre-certification process may actually drive up your costs as a patient if you are being evaluated twice for the same problem, and one of those exams is in the ER, with co-pays and the higher costs to you associated with that process.

So how can this be fixed? It actually is fairly simple, or so it would seem. Processes need to be streamlined and simplified. If a physician – not just an ER physician - examines a patient and feels a diagnostic test is needed immediately, there needs to be a process for that to occur, and for there to be some assurances of proper payment for emergent or urgent services provided in good faith. This process improvement is needed to provide appropriate care to citizens of Indiana. To allow insurance plan processes to delay necessary care to the possible detriment of patients should be intolerable, but that is exactly what is happening today.

Citizens beware! Your health plan may be hazardous to your health.

Bernard J Emkes M.D.

SB 372 SUMMER STUDY SIGN-IN SHEET

Project:	Study Committee	**Meeting Date:**	~~JULY 25~~ AUG 22, 2007
Facilitator:	Carol Cutter	**Place/Room:**	Conference Room 19, IGCS

Name	Title	Company	Phone	E-Mail
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MIKE CLAPHAN	EXEC DIR	IN ASSN OSTEOPATHIC	926 3009	MCLAPHAN@AOL.COM
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Christina Gilpatrick	Biller/acct Rec/Referral	Castleton Family Physicians-Dr. Clutter	317-842-2909	cgilpatrick@ecommunity.com rclutter@pol.net

SB 372 SUMMER STUDY SIGN-IN SHEET

Project:	Study Committee	**Meeting Date:**	~~July 25~~ Aug. 22, 2007
Facilitator:	Carol Cutter	**Place/Room:**	Conference Room 19, IGCS

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Libby Cierzniak		Baker Daniels	317-237-1336	Libby.Cierzniak@Bakerd.com

SB 372 Summer Study Sign-In Sheet

Project:	Study Committee	**Meeting Date:**	~~July 25~~ Aug. 22, 2007
Facilitator:	Carol Cutter	**Place/Room:**	Conference Room 19, IGCS

Name	Title	Company	Phone	E-Mail
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Michael Yoder	CEO	Southside Fam Med Grp	472-7815	michael.sfmg@comcast.net
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SHEILA DOLPH	FINANCIAL SERVICES MANAGER	ELKHART CLINIC	574-296-3963	sdolph@elkhartclinic.com
Rhonda Ludwig	Compliance Analyst	THE CARE GROUP, LLC	317 338-6373	rludwig@thecaregroup.com
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SB 372 SUMMER STUDY SIGN-IN SHEET

Project:	Study Committee	**Meeting Date:**	~~July 25~~ Aug. 22, 2007
Facilitator:	Carol Cutter	**Place/Room:**	Conference Room 19, IGCS

Name	Title	Company	Phone	E-Mail
Bernie Emkes MD	medical Director	St. Vincent Health	338-3068	bjemkes@stvincent.org
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Tyler Campbell	Legislative Assistant	House Republican caucus	232-9648	tcampbell@iga.in.gov
Julie Halbig	Atty	Hall, Render	977-1414	jhalbig@hallrender.com
Kim Stoneking	CEO	NAIFA- Indiana Indiana SHAC	844-6268	stonekingk@sbcglobal.net
PAT McGuffey Partner		LNV Consulting	6734215	pmcguffey@lnvconsulting.com

Wed 19th
1:00 pm
AMAL Building

4129 East Van Buren
Suite 150
Phoenix, AZ 85008

COPY

NIA

June 6, 2007

Member Name:
ID #:
Date of Birth:
Requesting Provider: **Dr. Michael Myers**
Place of Service: **CMNTY HOSP NORTH**
Requested Procedure/Service: **Sinus CT**
Authorization #: **7155C638**

Dear

National Imaging Associates, Inc. (NIA) reviews certain radiology requests to determine if they are medically necessary and a covered service under the CIGNA HealthCare* benefit plan.

We received a coverage request on Jun 04, 2007 for the following service(s):

Sinus CT

After review of the information submitted and the terms of your benefit plan, we have determined that the requested services will be covered. Your request has been approved for the above listed services if you are enrolled and eligible for benefits on the date(s) of service.

All benefits payable are subject to your benefit plan's provisions, limitations, and exclusions in effect at the time services are performed. The amount of your copayment or coinsurance may be impacted by the provider chosen. It is important for you to know this letter does not guarantee payment of benefits under your health benefit plan if you are not enrolled and eligible for benefits on the date(s) of service. Please refer to your benefit plan documents to get additional details about your benefit plan coverage.

EXHIBIT

LM 2 8/22/07

Phone: (317) 355-5555

CTScan

JULY 04, 2007

COMMUNITY IMAGING CENTER NORTH
PO BOX 19202
INDIANAPOLIS, IN 46219

called 7/10/07 gfbi spoke w/ & gave PA# put in for an appeal to insurance

91

Account Number: CIB
Original Balance: $1,309.00
Balance Due: $968.66
Admit Date: 06/05/07
Discharge Date: 06/05/07

Patient SS#: XXXXX
Insurance:
Policy:
Group #:
Subscriber:

Dear

Your insurance carrier has notified us that payment on the above account has been denied.

We are currently appealing this to your insurance carrier. If you have any questions regarding your insurance carriers denial, please contact them directly.

You will not receive any further statements from us on this account until we have received an answer from your insurance carrier concerning the resolution of this dispute. When this dispute has been resolved with your insurance carrier, we will begin our normal communications with you.

Thank you,

Customer Service Dept
(317) 355-5555

I27

4129 East Van Buren
Suite 150
Phoenix, AZ 85008

COPY

June 14, 2007

Member Name:
ID #:
Date of Birth:
Requesting Provider: **Dr. Michael Myers**
Place of Service: **COMMUNITY HOSPITAL NORTH**
Requested Procedure/Service: **Brain MRI**
Authorization #: **7164C076**

Dear

National Imaging Associates, Inc. (NIA) reviews certain radiology requests to determine if they are medically necessary and a covered service under the CIGNA HealthCare* benefit plan.

We received a coverage request on Jun 13, 2007 for the following service(s):

Brain MRI

After review of the information submitted and the terms of your benefit plan, we have determined that the requested services will be covered. Your request has been approved for the above listed services if you are enrolled and eligible for benefits on the date(s) of service.

All benefits payable are subject to your benefit plan's provisions, limitations, and exclusions in effect at the time services are performed. The amount of your copayment or coinsurance may be impacted by the provider chosen. It is important for you to know this letter does not guarantee payment of benefits under your health benefit plan if you are not enrolled and eligible for benefits on the date(s) of service. Please refer to your benefit plan documents to get additional details about your benefit plan coverage.

* "CIGNA" or "CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc., and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.

Services provided at:

COMMUNITY IMAGING CENTER-NORTH
P.O. BOX 19202
INDIANAPOLIS, IN 46219

MRI

Patient Accounts Coordinator
Phone: 317-355-5555 spoke w/ Jeff. Claims is working w/ Insurance and to wait 30 days.

Community Health Network

SAVE TIME AND PAY ONLINE AT eCOMMUNITY.COM

Guarantor Name:	
Account Number:	
Statement Date:	07/14/07
Ins. Co. Primary:	CIGNA HMO
Ins. Co. Secondary:	

Patient Name	Account Number	Admission Date	Discharge Date
		06/15/07	06/15/07

Date	Description	Charges	Payments	Adjustments	
06/25/07	Billed Balance				2995.00
06/25/07	COMMERCIAL ADJUSTMENT				778.70CR
07/11/07	CIGNA OR HEALTHSOURCE HMO PMT				244.20CR

YOUR BALANCE IS NOW DUE UPON RECEIPT OF THIS INVOICE. THANK YOU.

CURRENT BALANCE 1,972.10

PLEASE RETAIN UPPER PORTION FOR YOUR RECORDS
TO ENSURE PROPER CREDIT: PLEASE DETACH AND RETURN WITH PAYMENT IN ENVELOPE PROVIDED

Guarantor Name:
Account Number:
Current Amount Due: 1,972.10

B07166003684ELL061507001972101

AMOUNT ENCLOSED $ _____

SAVE TIME AND PAY ONLINE AT eCOMMUNITY.COM

TO PAY BY MASTERCARD, DISCOVER, VISA, OR AMERICAN EXPRESS FILL OUT BELOW

PLEASE CHECK CARD YOU ARE USING

MasterCard ☐ DISCOVER ☐ VISA ☐ ☐

CARD NUMBER	CHARGE AMOUNT
SIGNATURE OF CARDHOLDER	EXPIRATION DATE

FOR BANK USE ONLY: AUTH CODE _____

Please make checks payable to:

Community Hospitals of Indiana, Inc.
9500 Reliable Parkway
Chicago, IL 60686-0095

☐ PLEASE CHECK IF INSURANCE INFORMATION IS INCORRECT, AND COMPLETE FORM ON BACK.

984

STATE OF INDIANA)
)SS:
COUNTY OF MARION)

BEFORE THE INDIANA
COMMISSIONER OF INSURANCE

INTERIM STUDY COMMITTEE FOR S.E.A. 372
TRANSCRIPT OF PROCEEDINGS

ORIGINAL

HEARING OFFICER CAROL CUTTER
CHIEF DEPUTY OF HEALTH AND LEGISLATIVE AFFAIRS
INDIANA DEPARTMENT OF INSURANCE

MINI-AUDITORIUM, SECOND FLOOR
AMERICAN UNITED LIFE BUILDING
INDIANAPOLIS, INDIANA

SEPTEMBER 19, 2007

ACCELERATED REPORTING AGENCY
755 MORSE LANDING DRIVE
CICERO, INDIANA 46034
217/984-5050

TABLE OF CONTENTS

TABLE OF CONTENTS (continued)

P R O C E E D I N G S

HEARING OFFICER CUTTER: Thank you all for coming. We do appreciate your attendance, and hopefully the comments that you'll make this afternoon as we go through this last process.

Anybody who does not have an agenda, because we've got the agenda and then another follow-up -- Okay, everybody's good.

Tina, Jerry and I spent some time together over the last few weeks since we had the last meeting trying to, sort of, summarize and pull together, because we just covered so much information from so many different directions. Honestly, it was really, really helpful, even though I'm sure there were times when it seemed repetitive. It was still very helpful for us to really get a good grip on some of the technical issues with preauthorization to precertification processes; as well as on the provider side, some of the frustrations and difficulties that you folks have to cope with in using this kind of

procedure for your patients.

So, the first thing we thought we'd do would be to kind of review some of the comments that we had that we tried to categorize. And one of the first steps, probably the most important step, would be for us to look at some language that we had proposed by a couple of different interested parties in terms of, you know, maybe a place to start from.

We've also looked at other state laws that have similar kinds of requirements for preauthorization, kind of standard procedure. We don't think we're too off the mark with this. But we'd just like you to read through this.

Let's talk about Paragraph 1 first, and then we'll address Paragraph 2 separately. Anybody at this moment have any feedback on Paragraph No. 1, the proposed language?

Cool. I am going to take that as a yes.

You know, you may have some other words or substitutions or questions about definitions or

something, please raise those if you do. We are trying to be as simple and yet as specific as possible without being burdensome, and that is not always easy to do. So, you know, if any of you have issues in any of those areas about this language, go ahead and please let us hear your comments.

All right. So if I was going to ask you guys to vote, how many would vote for the language in Paragraph 1? How many would vote against the language in Paragraph 1?

Well, good.

For the record, that was about half the room voted for, nobody raised their hand against.

HEARING OFFICER CUTTER: Right.

The second paragraph came about as a discussion in terms of this sort of circumstance does happen. I don't know -- I can't give you any examples of frequency, but it makes it difficult for the providers who get into an evasive procedure of some sort and find another additional problem. Rather than

completing the procedure for the first problem, and then having to go back and say, okay, we've got another problem. We're going to have to reopen him, blah, blah, blah, which I think for most of us, especially as a patient, would think that that's probably not a very good use of our time and money. So we wanted to propose in the second paragraph, to see what your feedback was with this.

So kind of look through it and then let's hear comments if anyone has any, or suggestions or recommendations or changes or concerns about the issue.

Yes, ma'am. Would you stand up, honey, because she's got to hear you.

MARCIE HART, MANAGER OF OPERATIONS

ARNETT HEALTH PLANS

I'm Marcie Hart, Arnett Health Plans. I represent an HMO. I think as an HMO we might have difficulty, especially when using non network providers and facilities. I think that

we would have to put much better explicit medical necessity, we need to call that emergent. We need to get emergency in there. Because a lot of things may be medically necessary, but they don't necessarily mean emergent.

HEARING OFFICER CUTTER: I see. So it's not an urgent issue?

MS. HART: Right.

HEARING OFFICER CUTTER: Do you prefer the word emergency or urgent or is there another term that would be --

MS. HART: For us it would be emergency.

HEARING OFFICER CUTTER: It would be emergency.

Yes?

ROBERT CLUTTER, MD

INDIANA ACADEMY OF FAMILY PHYSICIANS

Well, I'm Bob Clutter. I would have to say I looked at that, and to me that is just -- of course, if you're doing a certain

procedure and another procedure needs to be done, you do it. You're not sitting there saying is this preauthorized or not. You've got to give the physician some credit for doing their job. And for you to say, well, sorry, that wasn't authorized.

So it's okay to take the appendix out but that ovarian tumor, well, that could have waited for another day. That's ridiculous.

I don't care what the circumstances are, you've got to give your physician some credit, and that kind of micromanaging just doesn't belong.

I would say the language is fine.

HEARING OFFICER CUTTER: Anyone else have any other comments or concerns about that second paragraph?

DAN SEITZ, MANAGING PRINCIPAL

BOSE PUBLIC AFFAIRS GROUP

Dan Seitz, S-E-I-T-Z. I'll give you my card.

I am going to have to respectfully disagree with the doctor.

MS. KORTY: We have a sign-in sheet going around.

MR. SEITZ: This is a brand new concept that we have not had the opportunity to discuss.

MS. CUTTER: Right.

MR. SEITZ: So this is the first time we have seen this. And I have not had the opportunity to discuss this with any of my clients. So, number one, there's no way I am going sign off on this until such time as that occurs.

Second of all, how does one know that it's covered procedures at the time? You don't.

Third of all, I agree with the doctor that any good physician, I would think, is going to do what is necessary at the time. What is necessary to be done and payment under an insurance plan, unfortunately, are not necessarily equated to one another. It seems

to me your responsibility as a physician is to take care of the problems without regard to whether you're going to get paid or not get paid.

This, in effect, is a mandate that says you've got to be paid, no matter what you've done, whether in our view it's medically necessary, number one.

Number two, whether it was necessary at the time.

And number three, whether in fact it was or was not a covered benefit.

So those are just some of the things that I've thought of as I sat here and just tried to absorb this.

MS. KORTY: Would it be more tolerable, and I know you can't speak for everyone again, if it said something to the effect of coverage may not be denied solely for lack of preauthorization? That can't be the only basis for the denial. As if the insured determines that it also was medically necessary covered by the plan.

MR. SEITZ: I think that would help. Again, I'm going to have to talk to some folks.

Where are you on inserting solely?

MS. KORTY: Probably after the word denied. Solely for lack of preauthorization.

MR. SEITZ: By the way, there's a typo in here. If a provider performs and additional. Is that and additional?

HEARING OFFICER CUTTER: An.

MR. SEITZ: A?

HEARING OFFICER CUTTER: A-N.

MR. SEITZ: An additional.

MS. KORTY: And an additional.

MR. SEITZ: Coverage may not be denied solely --

MS. KORTY: Solely for lack of preauthorization. That's just off the cuff, but something to that effect.

HEARING OFFICER CUTTER: Other comments?

Yes, ma'am.

LINDA BARRABEE, REG VP OF NETWORK

ANTHEM BLUE CROSS AND BLUE SHIELD

Linda Barrabee, Anthem Blue Cross Blue Shield. I have to agree with Dan. We haven't seen that language before.

Where I have a concern is, we will do predeterminations today for a physician when we see something that is going to be a covered benefit only when it's a medical necessity. What we find sometimes, when the claim comes in is a different procedure than what they asked for predetermination that they'll send in, it will be denied as being experimental, not medically necessary, show us that letter, it's two different things. And that concerns me a lot.

MS. MALOOLEY: Are you saying that would be the norm?

MS. BARRABEE: Right, right. But this would tell us we would have to pay it, regardless.

MS. KORTY: But if there was not a

different procedure performed but an additional procedure, would you still go ahead and pay for the procedure that was preauthorized?

MS. BARRABEE: The one that was preauthorized?

MS. KORTY: Yes.

MS. BARRABEE: Yes. It's the additional. If we authorize one procedure, we would pay for that. But what we found in some cases is it's either an add-on that wasn't sent in or it's a different case, it's close.

HEARING OFFICER CUTTER: The whole case is different?

MS. BARRABEE: Well, we have had gastric bypasses, and there are different kinds of gastric bypasses. And so a preauthorization will come in for one type and then another type will be done that may be considered experimental and not covered. Well, but you said they had coverage for gastric bypass. Well, you're correct, they did, but not that type.

HEARING OFFICER CUTTER: Do you not

specify that?

MS. BARRABEE: Yes, we do.

HEARING OFFICER CUTTER: If you specify -- if your approval is specific, then they don't have a leg to stand on.

MS. BARRABEE: Correct. But it's harming that situation. But I got it -- I had it preauthorized. Now I have to pay it and it might be experimental, it could be something that's maybe not a covered benefit or maybe wouldn't have been approved to begin with.

HEARING OFFICER CUTTER: Yes, Dr. Clutter.

ROBERT CLUTTER, MD

INDIANA ACADEMY OF FAMILY PHYSICIANS

I can understand that situation where you've been approved for one and maybe another one that's experimental would not be covered.

I guess the issue is if you're doing a procedure and if you do something while you're there that wasn't preauthorized, but if it

would have been covered, something appropriate that would have been covered, then we need to have some kind of language so you get paid, and you can't just dodge the bullet because you didn't do that.

And I would like -- I would also like to have some examples of situations where maybe that has occurred. Where they did something that was approved at the time and they did an additional procedure and then it was denied. If we could have some examples of something whereby, maybe, legitimately, it shouldn't be paid because it was unnecessary. It's hard for me to make that decision. I think some examples would be helpful.

LINDA BARRABEE, REG VP NETWORK

ANTHEM BLUE CROSS AND BLUE SHIELD

And to address, if you did a procedure would you go back and pay that?

I need to check with our precert because there is always that appeal right

though the precert. It might be that we need to go back and review that, see that it was medically necessary and we're going to pay for it. Not deny it just for the fact that you didn't get a precert.

And your example of, I went into the appendix and I saw a tumor. By all means, we want you to use your medical judgment to take care of that.

But I need -- I think that, that would go through our appeal process, and likely the medical necessity would be met and it would be covered. But I need to check on that. I don't remember.

HEARING OFFICER CUTTER: I have a question about that. I'm glad you went there. In terms of the procedure, because I don't think I'm clear on that. You talk about going through the appeals procedure. For me that means after the fact the patient files a grievance. Is that the same appeals process you're talking about or is there a separate one for preauthorization?

MS. BARRABEE: It goes through the same -- we have two processes: One when somebody gets denied for prior authorization that is really going to be before the service, and that can be appealed.

HEARING OFFICER CUTTER: Does it have to go through the same time line that the grievance and appeals procedure stipulating the statute?

MS. BARRABEE: Yes. It still has to go through that but those are turned around pretty quickly. Especially when we have a patient that needs to have surgery, we are going to make sure it gets turned around pretty quickly. It doesn't go through the same slow process as the other people, no.

HEARING OFFICER CUTTER: So you do --

MS. BARRABEE: Yes.

HEARING OFFICER CUTTER: -- filter those out?

MS. BARRABEE: And then the other one is after the fact --

HEARING OFFICER CUTTER: Right.

MS. BARRABEE: -- with the appeal. And it might very well get paid. But I'll need to check on that.

HEARING OFFICER CUTTER: Right. And that's okay, I understand. I just kind of wanted to get some clarification about that.

DAN SEITZ, MANAGING PRINCIPAL

BOSE PUBLIC AFFAIRS GROUP

Dan Seitz, again. I, too, would like to have samples of the circumstances that require this language. Because I think this is very rare. This is happening when, in fact, it's a procedure that is done because of something that's legitimately discovered in the process of one and it's something taken care of. Because I have trouble believing that really should be a problem. But that's not to say it isn't. I'd just like to know from whom.

HEARING OFFICER CUTTER: Is there any way for us to get some of that information,

Elizabeth?

MS. MALOOLEY: Uh-huh.

HEARING OFFICER CUTTER: Okay, that would be great.

Yes, ma'am?

MARCIE HART, MANAGER OF OPERATIONS

ARNETT HEALTH PLANS

I manage one of the claims shops at Arnette, and typically if an authorization is not matching up to the claim, there is usually processes to sum up whether a patient would be approved or denied. It will be looked at for medical necessity and if more information is needed, we'll ask for it, and they can't deny it.

HEARING OFFICER CUTTER: So that does make it a little quicker process?

MS. HART: Yes.

HEARING OFFICER CUTTER: One of the things that we kind of talked about at each of the meetings was, we were hoping to get from at

least one or two of the insurers some kind of feedback in terms of savings. Although I think Anthem did give us a ball-park number, maybe that first meeting in terms of, you know, when they took it away and then when they brought it back. Would you mind repeating that for me, honey, because I did not write that down and that would be a little helpful. Again, just ball park. I understand if they're not --

LINDA BARRABEE, REG VP NETWORK

ANTHEM BLUE CROSS AND BLUE SHIELD

You didn't miss it because I didn't have the specifics with me at the first one.

We do have from our radiology, and these numbers are specific to radiology. But prior -- at the end of 2004, when we did not require a precert, our radiology transferred 14 percent. They have gone down substantially. Right now they're looking at, and this is fully insured local group business for Indiana, it's about, since we put this in place, about a $5.8

million impact.

And this is the sentinel effect. This is not denial that someone calls in. Because, we talked about that last time. We don't deny that many services. This is that sentinel effect.

HEARING OFFICER CUTTER: Can you tell us what that 5.8, how that offers any basis in relation to the 14 percent figure that you gave us? That would give us a little better -- I think.

MS. BARRABEE: When looking at the trends, I'm looking at what the cost of those services on a per member, per month basis. So it dropped from where it was --

HEARING OFFICER CUTTER: Is there a number there, instead of a percentage there?

MS. BARRABEE: I'm looking to see, our actuary didn't give me an exact PMPM number. I can get that from him if we want the PMPM. He'd given me 30 million for the whole midwest and then gave me Indiana 5.8 million. 5.8 million and that's only for fully insured.

HEARING OFFICER CUTTER: And that's a decrease?

MS. BARRABEE: Correct. So, that would go right back in the claims cost.

HEARING OFFICER CUTTER: Okay.

MS. BARRABEE: On the regular -- that was on radiology alone.

On the precert overall, he pulled -- our actuarial person pulled some Milliman information, and said that a full package of precert, which is pretty robust, is going to be about 5.5 percent savings. So he applied those numbers to ours and said that by applying those numbers to our claims payments that's about $135 million.

MS. KORTY: $135 million since 2004?

MS. BARRABEE: No. This is using Milliman on our entire precert process. So if you took away precert code today, the way it is today, your cost could go up by some $135 million per year.

HEARING OFFICER CUTTER: In Indiana?

MS. BARRABEE: Yes.

HEARING OFFICER CUTTER: Thank you very much for bringing that. We really do appreciate it.

Yes?

DAN SEITZ, MANAGING PRINCIPAL

BOSE PUBLIC AFFAIRS GROUP

I, too, have some articles that I can share with you. These are from the American College of Radiology, the American Journal of Roentgenology. I can't pronounce it. And studies that were done in Minnesota and New Hampshire, one by Towers Perrin, the other by Price Waterhouse.

HEARING OFFICER CUTTER: Why don't you give those to the court reporter and we can make those part of the record.

MR. SEITZ: Since these are my only copies, it makes it kind of difficult.

HEARING OFFICER CUTTER: Later. Do it later.

MR. SEITZ: I will get you copies.

HEARING OFFICER CUTTER: That was one of the things -- one of the pieces we were really missing. We just kind of wondered, you know, what that -- what those savings have been.

Any more comments about the language?

We noted the concerns to the second paragraph and ISMA will follow that up and try to get us some better information, which since we've got you guys all on e-mail blast, we'll probably just e-mail blast that out once we get that.

The next issue was the clarification of the categories of care when preauthorization was required. We heard a lot of anecdotal evidence about certain situations in different facilities with different providers where stat conditions, I think for the most part, were the ones that they identified, were delayed for a period of several hours or almost weren't given a preauthorization to go ahead and treat the patient in that condition for a variety of different reasons. It was tough to get a hold

of people, there was a lot of back and forth, time delay, that sort of the thing. So, one of our questions is; we would like for one of the providers to tell us, we've written down the words urgent, acute, stat, and emergency.

MS. KORTY: And elective.

HEARING OFFICER CUTTER: And elective. And we need for a provider to tell us in ascending order from the least dangerous to the most dangerous what those are.

ELIZABETH EICHHORN

INDIANA STATE MEDICAL ASSOCIATION

The word provider -- Elizabeth Eichhorn, Indiana State Medical -- has been used in this meeting to refer to insurers and to --

HEARING OFFICER CUTTER: Okay, I should say physicians. Let me say physicians. Thank you, Elizabeth. I should have made that clear.

So it would be helpful for us to have

an understanding of those categories and how they vary from one to the other in terms of severity. Because that seemed to be the problem a lot of times with the preauthorization.

Yes?

ROBERT CLUTTER, MD

INDIANA ACADEMY OF FAMILY PHYSICIANS

Well, stat would be the most urgent.

HEARING OFFICER CUTTER: That is the most urgent?

DR. CLUTTER: Right now. And you're not going to get preauthorization for stat. When a stat happens you do it now, worry about it later and provisions need to be made for reimbursement under those circumstances. You're not going to get precertification for a stat. You get to it first then go after that later.

HEARING OFFICER CUTTER: I think one of the things that came out in that discussion

about the stat examples that we were given, was that these people were not in the emergency room for some -- isn't that right? They were not admitted to the emergency room and that was the difficulty because in the emergency room there wasn't any need for the physician to even worry about preauthorization. But for some reason, with these two stat conditions, these people had progressively --

MS. KORTY: They were decompensated.

DR. CLUTTER: If they were admitted directly into the intensive care unit, and taken straight to the cath lab that would have been stat, and they would have bypassed the emergency room, it's still stat.

HEARING OFFICER CUTTER: Still no pre-op.

DR. CLUTTER: Yeah, I mean, do it after the fact. But I think it's still the same kind of situation when you do two procedures in the same setting. If it's something that would have been authorized, we need to go ahead and authorize it after the

fact.

Emergent is maybe not do it now, but it's got to be done perhaps in the next few hours. And in those circumstances, if you -- my feeling is that should be treated just like a stat. You go ahead and do it and get the authorization after the fact.

But one of the recommendations from one of my constituents was that the payers, insurance companies, should have people on call all the time, just like we do, 24/7. You should be able to reach somebody and get an emergency authorization.

I don't know if they want to do that or not, but if they're not going to do that, then they've got to be prepared to provide authorization after the fact for emergent problems.

Urgent would mean it's not going to wait a month, it's not going to wait until next week --

HEARING OFFICER CUTTER: A day or two.

DR. CLUTTER: -- maybe tomorrow or the

next day. And maybe those things, you know, need to be precertified. There need to be some standards there as well.

And we need to be able to get a hold of somebody within minutes and get an authorization within 30 minutes or less, and that can be done.

And, of course, elective, we can do it anytime. We can take our sweet time about it, I suppose. Nevertheless, you've got to make arrangements and there's got to be some industry standards set so things are better than they are now.

MS. KORTY: Is there any category between urgent and elective? Something that needs to be done within the next few weeks. For example, if somebody, I don't know, maybe needing a stress test. Could that wait more than a couple of days, but it's not really elective, or is that considered elective?

DR. CLUTTER: A stress test would probably be urgent. If I want a stress test because the guy's got chest pain, that's

urgent.

An elective can be -- I don't see why an elective should take more than 24 hours to get an approval. I mean, that again is one of the suggestions, which I will read to you whenever you want to hear it, that I've been given.

HEARING OFFICER CUTTER: Well, why don't you read it now since we're on the topic.

DR. CLUTTER: Well, okay.

First of all, I am Bob Clutter, and I am here -- I've been asked to represent 2600 members of the Indiana Academy of Family Physicians, and 170 members of Community Physicians of Indiana, and 8000 members of Indiana State Medical Association.

So, concerned, the reason I was asked to come down here was because there was a concern that if we didn't have large volumes of irate, ensiferous doctors down here, that you might confuse the lack of large numbers of demonstrators for a lack of interest in the issue, which is not the case. This is a global

issue. And I would like for you to just imagine, if you will, 10,000 doctors up here standing with me yelling and screaming, tearing their hair out in frustration. That's basically the message that I was asked to convey. So you all would understand this isn't just a few disgruntled doctors who've had some bad experiences. This effects everybody. And I am not going to regale you with all the e-mails and comments I've had from different people on the issue. Suffice it to say, they are all pretty mad in feeling that the precertification process is intrusive and disruptive, time consuming, and it's expensive. We really need some relief here.

Most of their experiences, much like mine, I have got a part-time employee who spends about three hours a day doing these functions. So it probably costs about 50 bucks a day and over period of year that adds up.

The interesting thing is that nobody's complaining about patient care. I'm concerned about not being able to get things done. We

don't get denied. I've been in -- the whole time I've been practicing, I don't think I've ever asked for anything that was denied. Occasionally I'll have to write a letter of appeal explaining circumstances. On occasion I've talked to a medical director. But once they understand what it is we need and why we do it, it's always covered. It's always approved. And for that reason most of us perceive this to be kind of an unnecessary thing.

Now what you just told us about 135 million dollars saved, I have no idea where that's coming from, but it's not coming out my office, that's for sure. It tends to be more of an economic issue. So that's the message that I was sent down here to convey.

But personally, I am speaking for myself, and I guess on behalf of everyone else, I guess you can now understand that we're not going to do away with this problem. You presented some data on cost savings for the insurance industry. It's not going to make it

go away. And I've talked to some people in the insurance business in terms of precertification.

What we need to do is streamline it so it's not so ominous, so it's not so disruptive, so we don't have to spend 50 dollars a day for a part-time employee to do it for us.

One of our members e-mailed me some suggestions and I'll read them to you.

Said, maybe we can ask them to mandate the performance standards. For example, accept electronically or via fax, the confirmation received, tracking number given to the provider within five minutes. When you send it out, it's there.

Decisions based on precertification authorization must be sent back electronically or via fax to the provider within 30 minutes.

Precert prior auth requires medical review. The provider must be notified via electronically or via fax within 30 minutes.

Automated phone system authorization must take less than 10 minutes to complete.

Live phone assistance must be available to 90 percent of calls in two minutes, and all calls within 5 minutes.

Precert prior auth decisions and live phone assistance must be available 24/7.

Stop asking us to provide further proof of authorization after the fact.

Medical review of precert prior auth must be completed within 48 hours.

Medical records documentation requires precertification and prior authorization approval where the records documentation comes from the provider, other than the one requesting the service, must be obtained by the payer. Don't place the burden of obtaining the record on the provider.

Obviously, much more thought would be required to develop such service performance standards. This is just gives us some examples of food for thought.

I thought I would just read that. Obviously, this isn't something -- we aren't going to adopt anything today. It's just to

throw out that I think providers are overly burdened by this. It's costly, time consuming, and we want some kind of relief. If we could just get some standardization and cooperation from the payers, so that the process would be smoother, so we didn't have to take so much time, that's what we're looking for.

I think probably what you're going to need to do is form a committee and you will have to have people from the insurance industry and providers get together and decide what's reasonable and what is not reasonable.

I would hope it would be a cooperative thing. I hope it wouldn't be the insurance people sitting there trying to preserve every little clause they've got and providers going in there and trying to take back everything they can. I would hope it would be a cooperative spirit.

If the people participating understood maybe prior auth presert is a necessary thing, but let's just restrict it to the things that need to be preauthorized. And let's develop a

system that can be acceptable, something we can live with.

If there's any kind of standardization, that would be helpful. Because right now we have all these different companies, they all have different requirements, they change every quarter. We don't know who requires what and my gal just preauthorizes everything because she doesn't know what needs to be preauthorized and what doesn't. If we had some kind of standardization that would be helpful. I guess that's all I have to say.

MS. KORTY: Can I ask one quick follow-up, Doctor?

DR. CLUTTER: Yes.

MS. KORTY: You said you spend about 50 dollars per day on this. How many patients do you see in a typical day?

DR. CLUTTER: I see, well, we're a group of five, and we probably see a hundred patients a day.

MS. KORTY: So that's about 2 dollars

per patient?

DR. CLUTTER: No. About 50 cents per patient.

MS. KORTY: See, that's why I'm a lawyer. Math is not my thing.

DR. CLUTTER: Based on the time it takes for that employer, salary, benefits, and so forth, that's about what it costs us. About 50 cents a patient, and I think that's a lot.

HEARING OFFICER CUTTER: I don't know if you got to hear some of the other comments from the other two meetings, but one of the things, that, unfortunately is a reality in the marketplace is, and it kind of goes to some of the concerns that your group has. There are multiple companies doing business, and within those multiple companies they may have 10 or 15 different kinds of health insurance plans.

So each of those plans is a variance. They may have some consistency of preauthorization through those plans, that would seem reasonable and probably is so.

But the other piece is, is so much of

the population in the state of Indiana that has health insurance are under what is called ERISA plans, which are employer sponsored funded plans, not a plan with an actual insurance company. Those plans -- we have no authority over those plans. And about 71 percent of the folks in Indiana that have health insurance are covered by one of those plans.

Specifically, you'll see a large employer like one of the universities, a state employee, somebody who works for General Motors, Ford Company, any of those kinds of larger entities.

But even employers as small as 75 or even 50 people can have what is called an employer's self-funded plan. And those plans, no matter what we do with this information, they don't have to pay any attention to us, because they're regulated by the federal government not any state government.

I think that's a lot of the issue that you guys are faced with. I would be willing to bet that probably 80 percent of the patients

you see are covered under those self-insured plans. And we have an opportunity to say to them, well, you know, let's try to have some kind of consistency in standardization. I know that's frustrating because when we go through an exercise like this, ultimately we're probably only going to help maybe 20 to 25 percent of the folks in Indiana that have health insurance, just because of that fact.

DR. CLUTTER: When you say you have no jurisdiction, do you mean the Department of Insurance has no regulatory authority, or are you saying the State of Indiana has no legislative authority?

HEARING OFFICER CUTTER: Both.

DR. CLUTTER: So you couldn't go to the legislature and pass a law and say, hey, we want these standards applied to these ERISA plans?

HEARING OFFICER CUTTER: No. Federal law always trumps state law.

DR. CLUTTER: So you're telling me 80 percent of the people insured -- this whole

exercise is only for the 20 percent?

HEARING OFFICER CUTTER: Right, that is the sad truth.

DR. CLUTTER: I am sure glad I took the day off to come down here.

HEARING OFFICER CUTTER: Well, and the other thing that we have talked about, that you wouldn't know about was because of that issue, we've discussed having some kind of an indication on the patient ID card for their health insurance, that would let you know that.

We think that would be helpful for you and the patients, because then you're going to know that, that health plan that they're covered under was constructed by the employer, not by an insurance company. Even though an insurance company may be processing the claims for that employer and just charging a fee to process those claims so that employer doesn't have to hire somebody to do it.

DR. CLUTTER: Will these ERISA plans you're talking about hire Anthem or somebody --

HEARING OFFICER CUTTER: Yes. Yes. Yes.

MS. KORTY: To administer it.

DR. CLUTTER: To administer it. And so your telling me that Anthem and Aetna then are immune from anything that you might --

HEARING OFFICER CUTTER: For that claim.

DR. CLUTTER: For that claim. Well, you know in the spirit of cooperation you think the insurance companies might be inclined to apply the same kind of standard across the board for those? Or not?

MS. KORTY: It's not their call. It's not their decision.

DAN SEITZ, MANAGING PRINCIPAL

BOSE PUBLIC AFFAIRS GROUP

Doctor, the people that have to cooperate in those plans are the employers. It's not an issue of what Aetna and Anthem may or may not do. We are not the ones that

control that situation, we simply administer it, and that is part of the difficulty.

Many of these things that you would like to see happen have to happen at the federal level, under federal law, which would, frankly, make a lot more sense than going from state to state to state and having varying sets of rules and requirements in each state. But at least at the federal level, so far, we've been just in a deadlock in terms of performing. That may change with the elections next year. Who knows.

But in the end a lot of the problems that are constantly identified by physicians and other health care providers relate to the fact that we have a system that does not have a single pair. And if you want a single pair system, that will solve a lot of problems.

DR. CLUTTER: You know what, I think I'm about ready.

MR. SEITZ: It will solve some problems and it'll produce a lot of new ones.

DR. CLUTTER: Then we could probably

deal with this. As it is we can't even deal with it.

MR. SEITZ: That is the problem.

ELIZABETH EICHHORN

INDIANA STATE MEDICAL ASSOCIATION

Elizabeth Eichhorn, Indiana State Medical. Something I would like to say about the point that we have been discussing, when we talk about any type of state law or information for insurance plans, about the percentage of plans. I guess when we make a state law if you apply that philosophy that, okay this only affects 20 percent of the population, well, then we should pass no state laws, because there is no state law or rule that effects 100 percent of the population. Should we not have passed the uninsured law, the uninsured plan, the Governors plan, because that only can insure a percentage of the population? Should we have not passed the booster seat law because that effects only children under a certain age?

So it doesn't effect the whole population.

I wish emphasis -- so much emphasis was not placed on the fact that, okay, it's only 20 percent of the insured population that will have remedy or relief. You have to have state laws. Those 20 percent do matter. And we get lots of calls and complaints about the issues we bring to you to try to remedy. Otherwise, we would not bring them.

MS. KORTY: Elizabeth, I understand your comments, but I think the point on this particular part is 20 percent standardization is no standardization at all. You're still going to have, okay, all of the insured plans you only have to preauthorize these particular procedures, but the other 80 percent can do whatever they want and so the practitioner, who is being cautious, is going to call on everything, just like you're doing.

MS. EICHHORN: And I am not being controversial, but even just proposing to the Department today, that will bring relief to some of our members. And to those members, to

those patients, that matters. So I just wish so much focus would not go on this 20 percent or 30 percent number.

HEARING OFFICER CUTTER: We're not discounting that, it's just that we want the folks who suffer through those processes to understand why, even if we go through this, it probably isn't going to change their world.

DR. CLUTTER: Well, some of the things that are process things, so, even though it's an ERISA plan, if it's a precertifiction process, and if Aetna and Anthem is doing that, then Anthem can still comply with those standards.

I am talking about, you know, getting them done electronically or by fax and getting answers back within a reasonable time period.

HEARING OFFICER CUTTER: Right. Right. Right.

DR. CLUTTER: Those kinds of standards would still apply.

HEARING OFFICER CUTTER: And to that point that takes us to the third item under our

first hour is an appropriate time line for each category of care. That's one thing that the three of us have discussed in depth is, we think it's important to recognize the different levels in terms of preauthorization because of the restrictions that we've heard practitioners tell us they were under because they couldn't perform what they needed to perform, when they maybe needed to perform it. I think that's a very reasonable request.

So we were thinking in terms of -- and that's why I asked you to identify those four levels for us, so we could say, okay for electives, let's say you have to have a preauthorization done in five business days, something like that.

DR. CLUTTER: How about 24 hours?

HEARING OFFICER CUTTER: You don't need that for an elective surgery. You don't schedule those for three weeks anyway.

DR. CLUTTER: Not necessarily.

Excuse me. Dr. Matesic.

I would like to say something about that because these things change. If you see something acute today, it can be urgent in two hours. Things can change so quickly. So to really be fixed with these terms is ridiculous. It just cannot be used, except for stat. And acute means only new and it cannot be used here either. Things change quickly.

HEARING OFFICER CUTTER: I don't understand. So you don't see any value at all in establishing some kind of, like for a stat condition, there wouldn't have to be preauthorization. For an emergent condition they would have to do it within like a two-hour period, or a three-hour period. And then on an urgent condition, can be done within 24 hours.

DR. CLUTTER: I would say both stat and emergent should be after the fact. Because emergent, that can be done within an hour or

two. They're going to do it when they're going to do it. It's not going to bypass the ER and go to the cath lab necessarily. They're going to go ahead and get it done as soon as they can and any authorization is not going to be the first thing they think of.

HEARING OFFICER CUTTER: You're going to do those after the fact, then?

DR. CLUTTER: Yes.

Urgent, I would say urgent should probably be within 24 hours. I think within an hour. But I don't know why that can't be done. They should have people on call that should make those decisions, just like we do.

MS. KORTY: I think we cut you off, before you continue to talk could you state your name for the record.

DR. MATESIC: If you have somebody on the phone and you can actually deal with them, because of change, to deal with, that would make sense.

HEARING OFFICER CUTTER: Can we have your name please for the court reporter.

DR. MATESIC: Damir Matesic. I'll give you one of my cards. D-A-M-I-R M-A-T-E-S-I-C.

HEARING OFFICER CUTTER: Okay, Dan.

DAN SEITZ, MANAGING PRINCIPAL

BOSE PUBLIC AFFAIRS GROUP

You know, we have a statute on the books. I don't know if you've read it, but it controls time frames, emergencies, it's already there for your utilization and review. Now, if you want to talk about tweaking these, fine. And, you know, getting the term in here as emergent, urgent, I don't know how all that fits. But when we wrote the statute, emergency seemed to be the category that was acceptable to everyone. And we provide that for a period of at least 48 hours following an emergency admission, service or procedure, during which an enrollee, or the representative of the enrollee may notify the utilization review agent, in this case the preauthorization agent,

if you will, and request certification, or continuing treatment for the condition.

DR. CLUTTER: So it already says if it's an emergency, which would include your stat, then it would be authorized after the fact.

MR. SEITZ: Exactly. And there are provisions regarding telephone service, availability, all of that is in current law.

DR. CLUTTER: If that's in there, that's got be proved, because I've got people who sit on hold for 40 minutes.

MR. SEITZ: Unfortunately, it doesn't talk about how long you're on hold. I will concede that.

DR. CLUTTER: Well, maybe you should write that in there.

HEARING OFFICER CUTTER: And that says emergency admission, does it not? The statute?

MR. SEITZ: It's emergency admission, service or procedure.

HEARING OFFICER CUTTER: Emergency only, so if it doesn't come in through the ER

--

MR. SEITZ: Well, that's not necessarily ER.

HEARING OFFICER CUTTER: Okay. Well, that's why I'm asking.

MR. SEITZ: It's emergency admission. That could be, as he said, I think he said there were some cases where you have direct admission for cardio and some other procedures. You wouldn't necessarily go through the ER.

DR. CLUTTER: I mean, if I've got a patient in my office that's got pneumonia and respiratory insufficiency, I know he needs to be admitted but not as urgent or stat or emergent, but he needs to be in the hospital and put on oxygen, IV, and antibiotics. I need to make arrangements to get him directly admitted, that would still qualify as an emergency, even though he's not emergent.

MR. SEITZ: I believe so.

HEARING OFFICER CUTTER: The questions -- the other set of questions that we had, we've had a little bit of conversation about

who determines -- I think the scans were the area that seemed to have the most potential for abuse or that is where the industry felt like there was the most opportunity for review that they suffered abuse in that category more than anything else. So from one of the insurers or one of the HMOs, can you give us an idea of what that process is to establish --

I mean, in my brain, if you say I'm going to call in and preauthorize something, I visualize a line of people sitting at a call bank kind of process and they've got this binder in front of them and somebody calls in and says I've got a patient with so and so and they go alphabetically, whatever that page is and they look that up and they say yes or no, or whatever the circumstances are. I need to know if that's a correct assumption.

MARCIE HART, MANAGER OF OPERATIONS

ARNETT HEALTH PLANS

Marcie from Arnett.

In the HMO world there is no call in and give removal, it's submit the documentation and send something in writing back. We are held to specific standards for any situation which requires that. So in that case, in Arnett's instance, we only have a couple that need to be approved. The documentation would be submitted in writing and it would be reviewed by a lay person, not necessarily a nurse, who falls outside of the algorithm. The medical director would look at it, and only the medical director could deny that.

DR. CLUTTER: How is the data submitted, if not by phone? By fax?

MS. HART: Via fax or if you're a contractor providing you have on-line access so that you can submit electronically.

DR. CLUTTER: How long does it usually take to have that process to turn around and get an answer?

MS. HART: Our turn around time is between 24 and 48, although standard is 15 days for an elective, and 5 days -- I want to say --

for nonelective.

HEARING OFFICER CUTTER: Marcie, on the categories we were talking about earlier, when you say nonelective, does that ignore these urgent conditions, these stat conditions?

MS. HART: Urgent and emergent would be retrospectively, always. We don't think of it -- it's causing us more work to do it prospectively because we know it's going to be approved. We're going to tie up our phone lines, we're going to get our call reps and we're going to be transferring you around. Most likely you're not going to find out right then and there.

DR. CLUTTER: Do you ever get into an argument where the provider decided it was emergent, he went ahead and did it, and then you decide that this wasn't really an emergency and it could have been done electively.

MS. HART: No. Typically we don't look at that retrospectively. We don't have an authorization processor or an audit processor for all of the health plans, but --

LINDA BARRABEE, REG VP NETWORK

ANTHEM BLUE CROSS AND BLUE SHIELD

We wouldn't deny it. If it was medically necessary we would still approve it. If we saw a trend we might go out of office to but it want be condition if it was necessary if it would have been approved.

HEARING OFFICER CUTTER: So Anthem follows kind of the same description as what Marcie described that Arnett does?

MS. BARRABEE: Yes. I wanted to address the electronic topic. We take calls at Anthem via the phone, but that's not our preference. We prefer on-line. We have fax, but again, we prefer on-line.

But I will tell you for a number of years for a precert we have been trying to move this process on-line where we meet resistance and reluctance after we to get that moved on-line. We try to educate them, you don't have to sit on the phone, go on-line. You can

do it 24 hours a day unless they bring information.

I'll be honest, one of the standard lines I get when meeting with the physician is, I'm the only one that has Internet access in my office. They're afraid of their staff -- they're going to go shopping on-line and not do their work. And I can understand that. And I understand that's an issue. But we are offering that alternative. It's very resistant. It's very resistant.

HEARING OFFICER CUTTER: What about the fax process? Do you get much volume?

MS. BARRABEE: We get a lot by fax. But again, it's paper. So we're getting -- when that fax machine is going constantly you're getting hundreds, reams of faxes in every day. In radiology presert, it's a fine example, on a lot of those you can get our approval back immediately. You don't have to wait for someone to come back with it. And we still have a hard time getting people to use it, which is very disappointing.

MS. KORTY: So do you have significantly faster response time if someone submits electronically than if they submit via fax? And is fax faster than phone?

MS. BARRABEE: Yes. And it's cheaper. We do not want to have call centers with people sitting there, people sitting on hold for 40 minutes because then another phone is going to ring while they were on hold. Does it happen? Sure. When you've got a large volume, probably in the beginning of the year when you have the most new members that is when it picks up the most. But we really want it to go on-line. We are meeting with a lot of reluctance.

HEARING OFFICER CUTTER: Do you have any sense of, on a percentage basis between the on-line, the fax, and the phone, which one of those three methods you get the preponderance of your requests?

MS. BARRABEE: The phone.

HEARING OFFICER CUTTER: The phone still?

MS. BARRABEE: When I polled from a recent provider visit, it was a large provider group explaining about -- and this was specific to radiology. When I explained it to the entire group he said, how many are coming in via radiology? How many are coming in via phone, fax, and the web. It was like 5 percent on the web and about 10 percent fax. The rest were coming in on phone. The one provider that, that division representing the group, 100 percent of that physician's group were coming in via the phone. We'd really like to move it there.

DR. CLUTTER: Can I ask how many companies have that capability?

MR. SEITZ: All of them.

HEARING OFFICER CUTTER: Everybody.

DR. CLUTTER: Everybody? So we can do precertification work by electronically with everybody or by fax?

MR. SEITZ: Yes.

DR. MATESIC: May I respond quickly?

(Speaking to Mr. Seitz at side of room.)

MR. SEITZ: I am sure it varies. But you're going to get a much quicker response. I would have to ask.

MS. BARRABEE: It really depends on the procedure. If the algorithms are built into the system and a request goes in and it goes against it, you might get it back right away. If it needs to be checked and someone has to look at some other algorithms, then it might be a few hours, it might be the next day.

HEARING OFFICER CUTTER: Now, going back to some of the comments that were made earlier then for the stat and the emergent circumstances, for the most part those are after the fact anyway, right?

MS. BARRABEE: Correct.

HEARING OFFICER CUTTER: The time is not as critical on those as it would be maybe for something else that were coming in?

MS. HART: Although we'd like it in before the claim comes in, or the member calls on it.

HEARING OFFICER CUTTER: Yeah. Okay. So that helps us through, in terms of eliminating any concerns about those kinds of stat conditions, that was something that we had a sense of it was a big deal. And it sounds like at least from the division's prospective, you guys, you don't even go there until after the procedure is done. That is helpful to know.

You talked a little bit about the medical directors are the ones that create the list of the algorithms or whatever those forms are.

MS. HART: I wouldn't say the medical directors. There is a committee that does that, and typically they go by Millerman Roberts.

HEARING OFFICER CUTTER: Oh, do they? So they use an actuary?

MS. BARRABEE: We use a lot of input from the different societies.

HEARING OFFICER CUTTER: But then the folks -- since you still have such a volume of

phone calls, there's still the call center, they're sitting there probably looking at a screen of some sort where they're going to key in whatever information they are given to see what that pulls up.

MS. HART: Correct.

HEARING OFFICER CUTTER: Do they have any other -- do they have any other opportunity, as they are going through that, you know looking at the screen to see what those algorithms are. Do they have any other opportunity to step outside of the those parameters, or is there somebody that they can communicate with right away?

MS. BARRABEE: When it comes into Anthem, the first level is not a nurse. And it typically is going right by what is on that computer screen. If approved, it goes on. It can't be denied. The only time -- if it's medical necessity or it's outside the norm, it goes to the next level, which is a nurse. Nothing will be denied unless the medical director reviews it.

HEARING OFFICER CUTTER: Even the nurse can't deny it?

MS. BARRABEE: Not for medical necessity.

HEARING OFFICER CUTTER: We need to probably clarify that. Have you guys as carriers had many circumstances, or even, maybe I should ask the physicians as to where you had -- you said you've not ever had a denial because you preauthorize everything. But you've never had a situation of urgent or emergent stat condition where they were denied?

DR. CLUTTER: I haven't, no.

HEARING OFFICER CUTTER: Anybody else? Yes?

SEAN DUDDY, DIRECTOR MANAGED CARE

ST. FRANCIS HOSPITAL

Carol, this is Sean Duddy, I'm from St. Francis Hospital. I think one of the things we are missing regarding precert on-line, not every carrier does that. I wanted

to mention that first off. That's got to be corrected. I know a major carrier in this market is just now promising that that will be available for providers to do that on-line. And then even within the Blue Cross family, we may have an Anthem card come in through the hospital but that is not going through Anthem's system, they can go through the Blue Cross of Illinois, for example, which has a different process and we may have some other difficulties there.

MS. BARRABEE: That goes to that ASO which is a --

HEARING OFFICER CUTTER: That's a self-funded plan.

MR. DUDDY: The statement -- I don't want everybody to think that every insured that comes into the provider's office has the capability to have their stuff precerted through the Internet. There is still some confusion as far as who does have the capability to do it. There's even some headaches trying to set up everybody. We've

got turn over. We have certain things that you think you can get set up and do it for a doctor's office real quick and find that it takes a few weeks, a month to get your password and your log in and all that, but it's available.

I try to push it to our doctors at the hospital, you need to go out and use it. I just want to make sure that it has not left the impression that it's available for every insured that comes into the office.

HEARING OFFICER CUTTER: That is true, like she said, it could be depending upon the -- who the self-funded plan is with. I think there is probably a greater number of carriers who have the capacity, rather than don't.

MR. DUDDY: Within the last, I'd say two years really, that's kind of rolled out and has been more available. I have been to some doctor's offices that are in rural settings, and you can make jokes about how they aren't with the 20th Century let alone the 21st. You might find, I'll get on the computer with the

doctors and find they have the old AOL and it took five minutes before the page is up. So to ask them to go the Internet and do something, they kind of go, are you kidding? There's no way.

So, there's some catching up to do. But that system is still, I think -- radiology, what, March of '05, is that when that rolled out? It's still relatively new even a few years later, as far as educating them and letting them know they need to do that.

MS. BARRABEE: Correct. Right. Couple of things, first, I agree some rural areas might be difficult, but I'm talking Indianapolis. There's a lot of providers here that won't give their office access either. Yes, there are issues in rural, and that is something to work with.

Secondly, on the savings. I don't want to you to refer to it as savings, because being politically correct, we don't have any. Sentinal effect is more (inaudible). If you took it away your cost could increase that

much.

HEARING OFFICER CUTTER: I think we had comments of that effect in that first meeting.

MS. BARRABEE: Correct. It's the sentinal effect.

HEARING OFFICER CUTTER: A couple of carriers had experienced that. They did eliminate the preauthorization and all of a sudden, bloop.

DR. CLUTTER: That's probably why we are not going to be successful in getting rid of it. It would just make it easier.

HEARING OFFICER CUTTER: The last point of interest -- go ahead, Doctor.

DR. CLUTTER: One concern I would express, occasionally something happens. You order a test, you do something, just didn't think about it, or didn't get preauthorized, so it was denied because it wasn't prior approved, and it was legitimate. It would have been approved. But they don't pay you because you didn't go through the hoops and hurdles.

How often does that happen? How do insurance companies manage that situation?

Let's say I order a test or a big procedure, something that would have been approved but I didn't do it. Sorry. And I send the bill and it comes back with no prior authorization, we're not going to pay it. How often does that happen? Or, I guess, then can you appeal it after the fact and get it reversed, get paid? Or is this just gottcha?

MS. BARRABEE: Unfortunately, I have to say it depends on the member's benefit plan. You could do it after the fact, there may be a penalty because it wasn't precerted ahead of time. Initially, when the claim comes in on the system it will deny it as not prior authorized.

DR. CLUTTER: And then I presume people would then feel it because they said, well, gee, I'm sorry I forgot to do it, but it's clearly indicated, can you pay me? What happens? Do they get paid? Or are they going to get paid, typically?

MS. BARRABEE: Typically, on a PL if there's no precert penalty for not having it done, that is something that's a group issue. If it's a medical necessity, we are going to approve it. If you would have called ahead of time we would approve it. We would pay it.

MS. HART: I can tell you at Arnett, if it is not precertified, it will be denied. It is the physician's responsibility. Nonetheless, for an appeal, however, if your response is, I forgot, it is going to be denied. If it was an urgent issue and that is why I did not get the precertification, then it will be approved. A lot of it is because of facility finance because you want to be tight-reined for that authorization process.

MS. BARRABEE: Do let me clarify. As long as you're a network provider, if you send that patient to a non network provider, it's not likely going to get authorized, unless it's an emergency issue.

DR. CLUTTER: That wouldn't have been approved anyway. You're talking about the ones

that would have been approved --

MS. BARRABEE: Correct.

DR. CLUTTER: -- you have the ability to not pay it, so you don't.

HEARING OFFICER CUTTER: Anybody else want to weigh in on that topic?

Any other just general comments, concerns, anything that you guys think we really missed the mark on, or that you really thought we were going to talk about and we haven't talked about?

I know the bill contained two or three other things, but I think we've already determined over the first couple of meetings that those were things we probably wouldn't have any opportunity to really try, for a variety of reasons. So that is why we kind of pulled back to the preauthorization. That was the main focus of bill anyway.

This is just me, I'm still stuck on that logo on the ID card that will let me know if they're self-funded or fully insured, and we've heard from the industry that there is not

a huge objection to that.

So, anybody else have any comments about that?

MR. DUDDY: My clients will keep bothering you about the ERISA plans.

HEARING OFFICER CUTTER: Well, you know, as a former agent, this is a very self-serving thought for me, and let me tell you why, because for me to get beaten up over an insurer issue that's not an insurer issue, I would rather be able to beat up the employer and say this is his call. This wasn't the insurance company. And I would think the industry, the insurers at least, would prefer that, to have the patient know that it was an employer benefit design and a call rather than, you know, the evil insurance company making that call.

MS. KORTY: I can see it being a benefit to the providers too, because then you can tell your patient, you need to talk to your employer. They're the ones who are denying this, just go talk to your human resources.

HEARING OFFICER CUTTER: Well, unless anybody has anything else?

I have no idea what time it is.

MR. SEITZ: It's 2:20.

HEARING OFFICER CUTTER: Is it. Okay. I don't suppose anybody minds getting out a little bit early today. We ran right through three o'clock the other two meetings.

Again, it's been very, very helpful for us, all of you from all the different comments, and all the different explanations, concerns and issues that you've raised, it's been very, very helpful. Thank you so much.

DR. CLUTTER: We're all done with the meeting, right?

HEARING OFFICER CUTTER: We are. And we'll have -- the ISMA will have some information that we'll e-mail out to everybody, and take comments on some of the language that we discussed today as well. Thank you.

(Hearing ended at 2:25 p.m. on September 19, 2007.)

STATE OF INDIANA)
) SS:
COUNTY OF JOHNSON)

I, Michelle L. Linton, Notary Public and Shorthand Reporter in and for the County of Johnson, State of Indiana, do hereby certify that the foregoing hearing was taken on behalf of the Department of Insurance, in the matter of SB 372, beginning at 1:00 p.m. on the 19th day of September, 2007;

That said hearing was taken down in stenograph notes and afterwards reduced to typewriting under my direction and that the typewritten transcript is a true record, to the best of my knowledge and belief;

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my notarial seal this 12th day of October, 2007.

Michelle L. Linton
Notary Public
Residing in Johnson County

My Commision Expires:
December 15, 2013

I agree that it's not what I had hoped to find. But it is the only concrete thing I've been able to turn up. The way we try to explain these things to the policymakers is that the financial costs of health care are just like any other issue running over budget - you have to look for small ways to cut costs to eventually make big changes in your budget. 4% may sound small but the result of not allowing us to do it is that premiums will rise by 4% - probably not the result anyone is looking for.

Shannon Meroney
State Government Relations Specialist
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From: Seitz, Dan (BPAG) [mailto:dseitz@bosepublicaffairs.com]
Sent: Tuesday, September 04, 2007 1:10 PM
To: Meroney, Shannon P; Weldon, Maureen C; Stefan, Bobbie
Subject: RE: Request

Thanks Shannon. This is good although somewhat dated. If the testimony of the industry is true, i.e., it is using UR much more sparingly than has been the case in the past, it would suggest that this number may actually be somewhat less than 4%. Further, the way that our policymakers will look at this is that 4% is only $40 per $1000 of premium and that the administrative burden on the system far outweighs the savings. Dan

From: Meroney, Shannon P [mailto:MeroneyS@aetna.com]
Sent: Tuesday, September 04, 2007 12:13 PM
To: Weldon, Maureen C; Stefan, Bobbie; Seitz, Dan (BPAG)
Subject: Fw: Request

For Indiana. Good stuff on UR $ savings.

Shannon Meroney
Aetna
State Government Relations
512-731-6615 cell

Anne Doran, representing AHIP, has been asked by Sen. Pat Miller to comment at the next Health Finance Commission on this coming Monday, September 10 at 1:00 p.m. on the issue of how insurers are handling prosthetic device coverage for insureds. Few states appear to have addressed the issue and often the issue is confused with coverage for the military which is a VA issue.

Thanks for your attention, Dan

From: Charles_Stuart@BCBSTX.COM <Charles_Stuart@BCBSTX.COM>
To: Meroney, Shannon P
CC: jfowler1@humana.com <jfowler1@humana.com>; JOHN.OATES@CIGNA.COM <JOHN.OATES@CIGNA.COM>; jwolfe@tahp.org <jwolfe@tahp.org>; pmccandless@terralsmith.com <pmccandless@terralsmith.com>
Sent: Tue Sep 04 11:15:52 2007
Subject: Re: Request

A colleague of mine shared the following:

Minnesota
The Minnesota Council of Health Plans and the Chamber of Commerce requested Towers Perrin to analyze the impact that various managed care oversight proposals would have on the cost and quality of health care. The "Analysis of Health Care Mandates and Controls" (March 1999) concluded that these provisions would significantly raise an HMO member's annual premium.
The proposals that were analyzed include:
* Any willing provider legislation (10.5% - 14%);
* Mandated coverage for alternative providers and treatments (6% - 7%);
* Elimination of utilization review (4%); and
* Mandated coverage of experimental treatments (2.5%).

New Hampshire

The New Hampshire Business and Industry Association engaged the firm of PriceWaterhouseCoopers to analyze the cost impact of draft legislation to regulate managed care plans. The "Review of the State's Proposed Draft HMO Accountability Act" (April 1999) estimated that its provisions would raise plan premiums by a total of 2.1% to 5.4%.
The specific provisions of the bill that were reviewed would:
* Define UR as the practice of medicine and hold a plan's medical director responsible to this standard when UR decisions are made (2% - 5%); and
* Create an external review process to resolve enrollee grievances (.1% - .4%).

Charles Stuart
Divisional Vice President
Government Relations
Blue Cross Blue Shield of Texas
512/231-7606

Are any of you aware of any research or articles showing the dollar/cost savings we see from pre-cert requirements? Oates and I need it for another state. Thanks!
Shannon Meroney
Aetna
State Government Relations
512-731-6615 cell

Journal of the American college of Radiology - on savings related to preauthorization's of CT and MRI

http://www.jacr.org/article/PIIS1546144006002092/abstract

Bobbie Stefan
Region Counsel - North Central
Ph. 312-928-3851
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Volume 3, Issue 11, Pages 851-859 (November 2006)

ABSTRACT
FULL TEXT
FULL-TEXT PDF (190 KB)
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Preauthorization of CT and MRI Examinations: Assessment of a Managed Care Preauthorization Program Based on the ACR Appropriateness Criteria® and the Royal College of Radiology Guidelines

Arye Blachar, MD[a b], Sigal Tal, MD[b c], Anat Mandelc, Ilya Novikov, PhD[c], Gabriel Polliack, MD[d], Jacob Sosna, MD[e], Yehuda Freedman, MD[c], Laurian Copel, MD[b c], Joshua Sherman, MD, MBA[b c]

Purpose

To evaluate computed tomography (CT) and magnetic resonance imaging (MRI) utilization patterns before and after the implementation of a preauthorization program based on the ACR Appropriateness Criteria® and the guidelines of the Royal College of Radiologists.

Materials and Methods

All CT and MRI requests received at the preauthorization center and CT and MRI examinations actually performed were identified by our health care service's centralized computerized database between January 1, 2000, and December 31, 2003. The obligatory preauthorization of CT and MRI requests was established for CT in September 2001 and for MRI in February 2002. All ambulatory CT and MRI examination requests sent for approval during the study period by most of our health care physicians were included in the study. The preauthorization program model is presented, and multiple parameters were evaluated from January 2000 to December 2003, before and after preauthorization was established.

Results

Before preauthorization was required, the CT and MRI utilization rates were constantly increasing by 20% and 5% per year for CT and MRI, respectively. After preauthorization was implemented, CT and MRI annual performance rates decreased from 25.9 and 7 examinations per 1,000, respectively, in 2000 to 17.3 and 5.6 examinations per 1,000, respectively, in 2003. The decreases in the utilization of MRI and CT imaging between 2001 and 2003 were 9% (12,129 compared with 11,070 MRI examinations) and 33% (81,223 compared with 57,204 CT examinations), respectively, resulting in substantial, statistically significant cost savings. The deferral rate ranged from 7.5% to 12.2% (mean = 9.8%) for CT and 13.9% to 21.4% (mean = 17%) for MRI. Deferred cases in CT were most commonly in neuroradiology, musculoskeletal radiology, and CT angiography (ranges of deferred cases 9% to 12%, 11% to 12%, and 10% to 12%, respectively). Deferred cases in MRI were most commonly in abdominal and chest radiology (ranges of deferred cases 32% to 37% and 20% to 31%, respectively). Computed tomography was more commonly utilized inappropriately by pediatric professions, and MRI was more commonly utilized inappropriately by medical subspecialty professions.

Conclusion

Preauthorization of CT and MRI requests results in a substantial decrease in utilization of these modalities with reduction in imaging costs.

SB 372 SUMMER STUDY SIGN-IN SHEET

Sept. 19
~~Aug. 22~~

Project: Study Committee

Meeting Date: ~~July 25~~, 2007

Facilitator: Carol Cutter

Indiana Academy of Family Physicians

Place/Room: Conference Room 19, IGCS

Name	Title	Company	Phone	E-Mail
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AGENDA

INTERIM STUDY COMMITTEE FOR S.E.A. 372

September 19, 2007

1:00-3:00 PM
American United Life Building, mini-auditorium, 2nd floor

Conducted by: Indiana Department of Insurance
Coordinator: Carol Cutter, Chief Deputy of Health and Legislative Affairs

Attendees: Please sign the sign-in sheet *Legibly!*

Note taker: Linda Merkl, Associated Reporting

1:00 PM — **Review of Comments from Prior Meetings**

Pre-authorization/pre-certification language to help establish some standard procedures

Clarification of categories of care when pre-auth is required

Appropriate timelines for each category of care

2:00 PM — **Questions we need answers to**

Who determines what scan is appropriate for the various health conditions?

How is that information communicated to the "call center" responders?

What is the procedure when a denial occurs for a stat or urgent condition?

Outsourced (ouf-of country) call center concerns

2:30 PM – 3:00 PM — **Conclusions/Wrap Up**

Pre-auth language and procedures
ID card logo for fully-insured/self-funded distinction
Others?

Proposed Language

When prior approval for a covered service is required of and obtained by or on behalf of a covered person, the approval shall be final and may not be rescinded by the payor once the service has been provided, except in cases of fraud, misrepresentation, nonpayment of premium, exhaustion of benefits, or ineligibility.

During an approved surgical or other invasive procedure, if a provider performs and additonal covered procedure due to medical necessity, coverage may not be denied although the additional procedure was not included in the original pre-authorization approval.

October 19, 2007

Carol Cutter
Chief Deputy of Health and Legislative Affairs
Indiana Department of Insurance
317-232-5695
ccutter@idoi.in.gov

RE: Indiana Department of Insurance Study Committee

Mrs. Cutter,

Thank you for chairing the round of Study Committee meetings held in July, August and September. Unfortunately, I was not able to attend the September meeting because of a scheduling conflict. However, I do want to follow up on your request for costs to private practice physicians associated with complying with insurance companies' requirements for referrals, pre-certifications and prior authorizations. I would also like to address the issues of standardizing 1) EOBs, 2) Uniform Insurance Cards, and importantly 3) A Uniform Timely Filing Limit.

1) Referrals, Pre-Certifications, Prior Authorizations
   a. As a primary care office (Family Medicine), we probably feel the impact of these requirements more than most specialists. This is because as the patients' medical home, we are on the front line of patient care and not able to pass these responsibilities on to another provider.
   b. If we do not provide these services to our patients, they will not/cannot get the tests and treatment they need. The problem, as we see it, is that these requirements add to our costs but do not add to our revenue.
   c. Doctors' offices operate on a thin margin without the additional costs associated with ever-changing Referral, Pre-Certification, and Prior Authorization requirements. Additionally, requirements differ from policy to policy within the same insurance company as acknowledged in the meetings by the insurance companies represented. Despite publications and web sites provided by the insurance companies to help navigate their requirements, keeping track of the multitude of requirements is literally impossible. In a market where doctors have to fight with Congress and CMS every year to avoid real and significant cuts in reimbursements rates and have experienced actual cuts in reimbursements from private insurance companies, doctors have to see more patients just to maintain their revenue stream. Over the long-term, this risks the health and well being of patients.
   d. While we are told by insurance companies that in an emergent/urgent situation, the facility rendering the service can in fact perform the service without the Pre-Certification, our experience has been that they will not. This is understandable, as they have no control over the Pre-Certification process and will not be paid by insurance companies without Pre-Certification.
   e. As a primary care office, we frequently order CT Scans and Dopplers based on urgent need. These scans are typically of the head or abdomen due to a sudden onset of symptoms, worsening condition, sever abdominal pain, or change in mental status. While

we have not had any test denied, we average approximately 10 hours per week for Pre-Certifications of these tests.

f. Our office spends approximately 5 hours per week processing Prior Authorizations for patients. This is kept to a minimum for new prescriptions, because if the pharmacy calls to ask for a substation of the new prescription based on the insurance company's formulary, our doctors authorize the substitution if possible. Still the chart has to be pulled, reviewed, and refiled. The majority of these 5 hours is for processing Prior Authorizations resulting from a change in the insurance company's prescription formulary or from a patient's employer changing insurance companies. (It is not uncommon for an employer to change annually, in order to minimize premium increases.)
    i. As an example, please refer to the included letter from Cigna Pharmacy Services Center, dated July 08, 2007 RE: GUIDELINES FOR PROTON PUMP INHIBITOR (PPI) COVERAGE FOR CIGNA PLAN PARTICIPANTS (Revised 7/1/06)
    ii. This patient was being successfully treated with Nexium prior to changing insurance companies.
    iii. In order to continue the patient's current course of treatment, the patient's chart was pulled, the doctor had to review the chart, complete the form, have it faxed back to Cigna and the chart had to be refiled.

g. In calculating our costs for Referrals, Pre-Certifications, and Prior Authorizations, I analyzed several factors:
    i. The average number of Referrals, Pre-Certifications, and Prior Authorizations per week,
    ii. The average staff time to process each Referral, Pre-Certification, and Prior Authorization (including Nursing and Medical Records staff time),
    iii. The average Physician time to review the requests and patient's medical record, and to complete the required documentation for each Referral, Pre-Certification, and Prior Authorization,
    iv. Costs associated with the staff and Physician time,
    v. The average weekly costs were then annualized using a 50-week year.

h. I believe that our costs associated with Referrals, Pre-Certifications, and Prior Authorizations are likely less than most other medical offices as our practice measures consistently beat the national practice management benchmarks of the Medical Group Management Association (MGMA). We estimate our cost at approximately $25,000 per FTE physician per year to process Referrals, Pre-Certifications, and Prior Authorizations.

i. I understand the insurance companies' desire to contain costs and that there is no easy solution. However, with their current procedures, costs are being shifted to providers, who are struggling with increasing costs and stagnant reimbursements. I would like to suggest the following two possible solutions to the issue of Referrals, Pre-Certifications, Prior Authorizations:
    i. The legislature could mandate that insurance companies' be allowed to universally require Referrals, Pre-Certifications, and Prior Authorizations from all providers for a fixed period (1-2 years) after contracting. During this period of universal requirement, the insurance companies can monitor provider performance, flagging a percentage of providers whom they deem as "over utilizers." Insurance companies can require these "over utilizers" to continue with the Referral, Pre-Certification, and Prior Authorization requirements until they meet predetermined utilization standards.

1. Insurance companies are already implementing "quality initiatives" and quality ratings of providers. As such they have demonstrated that they are currently collecting treatment and testing patterns of providers. This data would be useful and less expensive to all parties in monitoring provider performance.

ii. This proposal would require all health insurance companies to pay an annual fee as part of their insurance licensing requirement to cover the cost of the state collecting data on quality indicators and rating providers based on those indicators. Because of their medical expertise, representatives of each medical specialty would define the clinical quality care indicators and rating scale, while representative from the insurance companies would define the non-clinical indicators and rating scale. Providers below a predetermined rating level could be required by insurance companies to obtain Referrals, Pre-Certifications, and Prior Authorizations. This recommendation is based on extending the experience and concept of CAQH (Council for Affordable Quality Health Care) to a State of Indiana clearinghouse for quality care. CAQH demonstrates the experience many insurance companies have successfully collaborating in the formation of an organization to gather and maintain common data. CAQH collects and maintains credentialing data for its member insurance companies. Although the CAQH name indicates that the organization promotes quality health care, it does so in the limited scope of credentialing. This type of State clearinghouse would serve several functions.

1. Ensure an impartial and consistent monitoring and rating of providers, which would give patients, providers and insurance companies objective benchmarks. Unfortunately current insurance quality measures are not based on quality of care, but cost containment for them.
2. Save Insurance companies money, because the costs for analyzing and rating the data would be spread over many companies and would give insurers an objective measure to determine which providers needed monitored instead of monitoring all providers,
3. Save most providers money as it would reduce the number of Referrals, Pre-Certifications, and Prior Authorizations required.

2) EOBs

a. Uniform EOBs would make it easier for patients and medical offices to understand Explanations of Benefits. Currently every company has their own format, which slows the review process and consumes more staff time. I have provided examples of various EOBs for your benefit and the benefits of legislators if required.
b. As insurance companies and government push providers away from paper and towards electronic transactions, Uniform EOBs would allow easier programming of auto-posting features in medical billing software and slow the increase is costs.

3) Uniform Insurance Cards

a. Uniform Insurance Cards would simplify the gathering and entry of insurance information in to medical office billing systems. Again, every company has their own format, which slows the review process, consumes more staff time and results in billing errors. I have provided examples of various insurance cards for your benefit and the benefits of legislators if required.
b. Uniform Insurance Cards would allow for scanning of insurance information into our billing software. This would decrease billing errors and decrease staff time spent entering data thereby lowering the costs of healthcare.

c. The following minimum information should be on every insurance card (it should be in the same location on every card as well)
    i. Policy Holder Name
    ii. Covered Individual Name
    iii. Policy Number
    iv. Group Number
    v. Copay Amount
    vi. Paper Claims Filing Address
    vii. Electronic Claims Filing ID#

4) Uniform Timely Filing Limit
   a. Currently, Indiana has no legislation regarding Timely Filing Limits. Insurance companies dictate their own timely filing limits, which can be as little as 45 days from the date of service.
   b. Many companies actually penalize contracted providers with shorter timely filing limits than non-contracted providers.
      i. For example, CIGNA requires participating providers to file claims within 6 months from the date of service, and non- participating providers to file claims within 1 year from the date of service.
   c. Indiana's Medical Professionals provide a valuable service to Indiana's citizens, and Indiana's citizens contract with insurance companies to pay for medical services rendered. Unfortunately, it seems that with investor pressures for record profits and the competition to lure the best insurance administrators with lucrative contracts has led insurance companies to look for ways lower actual healthcare expenditures. One method to lower healthcare expenditures seems to be to deny and delay payment for services rendered.
   d. Indiana's Medical Professionals need to be paid for services rendered in order to continue providing said services. Unfortunately, while providers do make every effort to file claims in a timely manner, as it is not in the best interest of the provider to hold claims longer than necessary, some filing deadlines are missed for a multitude of reasons. Typically, this is because the patient has given the provider inaccurate insurance information, but can also be because a charge was simply not entered at the time of service.
   e. In July 2006, a law went into effect (SB147) recognizing a medical professional's right to be paid for services rendered, beyond 365 days after a patient's date of service by placing a two year limit on a medical professionals ability to request additional payment for an under paid claim. The same law gives Insurance companies two years to find and correct their payment mistakes by demanding a repayment of money it over paid a medical provider for health services rendered.
   f. <u>I would like to suggest that the Indiana Generally Assembly establish a Uniform Timely Filing Limit of two years from the date of service, thereby creating parity with the insurer's ability to demand repayment of money in overpaid for health care services. This will eliminate disparate and arbitrary deadlines, which result in limiting payment for services rendered, giving medical provider's sufficient time to discover and resolve billing errors, and providing insurers the necessary cut-off for reconciling their financial obligations.</u>
   g. <u>I would further like to suggest that the Indiana Generally Assembly establish a Timely Filing Limit of 6 months from notice or two years from the date of service, whichever is later, to file with the insurer responsible for the claim, when the original claim has been</u>

filed in a timely manner to a payer who is later determined not to be responsible for the claim.

h. At the second Committee Meeting, a representative from one of the insurance companies stated that they could not support a 2 year timely filing limit because they need to be able to close their books at year end in order to project future expenditures and premium adjustments. In other words, they need to know their current obligations and expenditures in order to budget for next year with certainty. This argument, however, is a red herring.
    i. Provider offices make current expenditures and future budgets based on practice cash flow. When insurance companies take-back money paid to a provider, up to 2 years after the fact, they are in affecting our "closed books" and instilling uncertainty into our budget process.
    ii. Depending on the date of service, expenditures are already carried from one year to the next, yet insurance companies are able to project future expenditures and premium adjustments.
    iii. The amount of money involved in "late" filing is statistically insignificant, and providers will continue to file claims as promptly as possible. It is not in the providers' best interest to hold claims longer than necessary. Insurance companies will have sufficient data to project future expenditures, especially after the initial year.

Again, thank you for considering my input in this process. I am forwarding the referenced materials under separate cover. If you have any questions or need clarification on any issue, I am always available. You can reach me by direct cell phone, direct office phone, fax, or email as outlined below.

Sincerely,

Michael E Yoder, MPA CAPPM EFPM
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